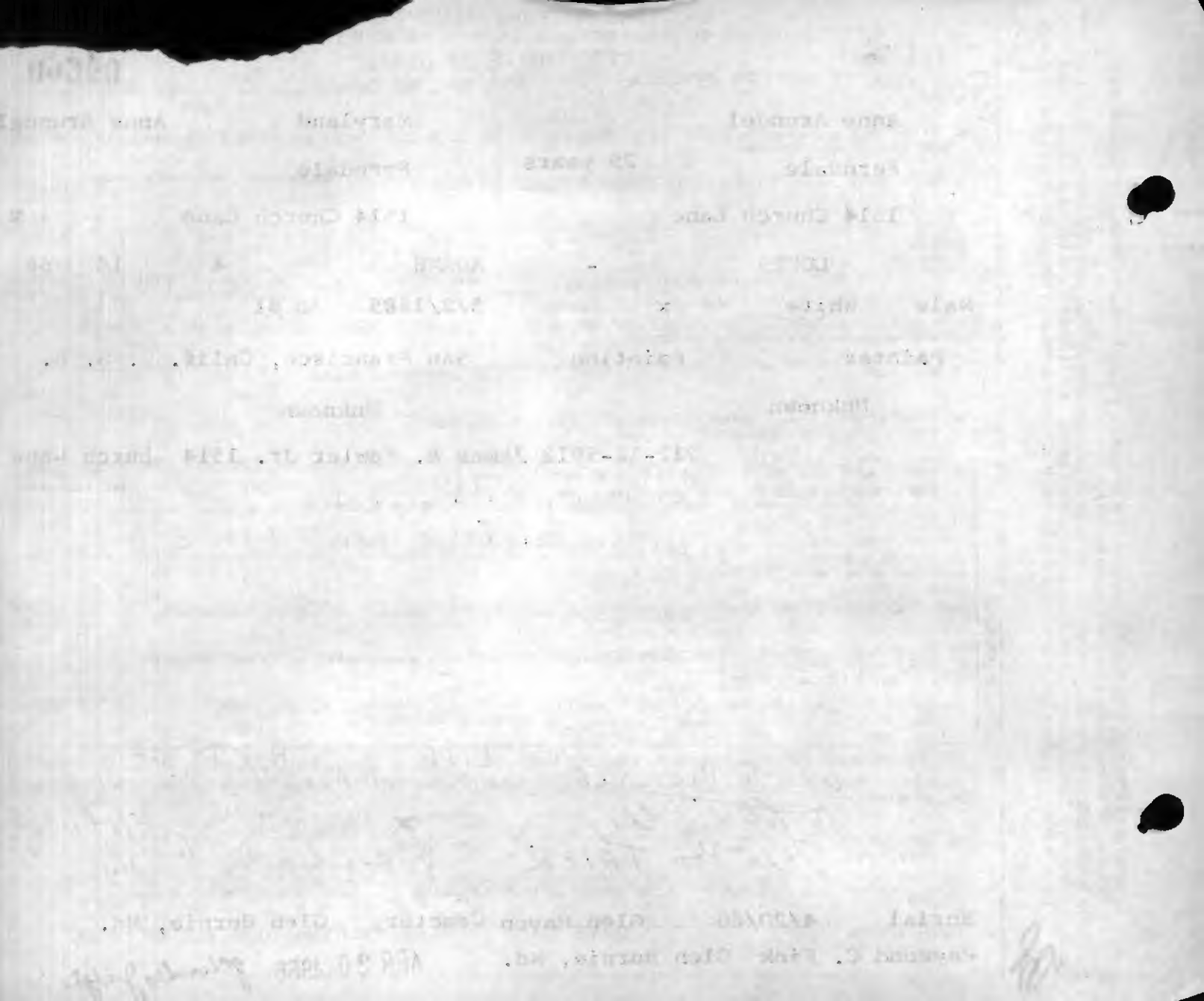


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET 04660											
CERTIFICATE OF DEATH						04660					
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ferndale c. LENGTH OF STAY IN 1b 25 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1514 Church Lane						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ferndale d. STREET ADDRESS 1514 Church Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOUIS			First Middle Last ADAMS			4. DATE OF DEATH 4 18 1966			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/2/1885		9. AGE (In years last birthday) 80 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (County & State, or foreign country) San Francisco, Calif.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 212-12-5912		17. INFORMANT James E. Fowler Jr.			Address 1514 Church Lane		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. Arteriosclerotic heart disease DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 Apr. 18 , 19 66 , that (I) (we) last saw the deceased alive on 5 Mar. 1966 , and that death occurred at 10 AM , from the causes and on the date stated above.											
22a. SIGNATURE Joseph Taler						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4/18/1966		
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER						22d. ADDRESS 95 Hymel Rd. Glen Burnie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/20/66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			23d. LOCATION (City, town or county) (State) Glen Burnie, Md.			
24. FUNERAL DIRECTOR Raymond C. Fink						ADDRESS Glen Burnie, Md.			25a. REC'D BY REGISTRAR APR 20 1966		
									25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> 1 (M) 04661 </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div> 04661 </div> </div>											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVA c. LENGTH OF STAY IN 1b Years 02-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RIVA, ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVA d. STREET ADDRESS RIVA ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EMMA ARDELIA AISQUITH				4. DATE OF DEATH Month Day Year APRIL 13 1966							
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 1, 1874		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Prince George Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK P. BURGESS						14. MOTHER'S MAIDEN NAME SOPHIA KIRBY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 217-38-3008		17. INFORMANT EDWARD AISQUITH / RIVA ROAD, RIVA, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. arteriosclerotic cardio-vascular disease DUE TO (b) disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July , 19 40 , to Apr. 13, 1966 , that (II) (we) last saw the deceased alive on April 12, 19 66 , and that death occurred at 7:20 AM from the causes and on the date stated above.											
22a. SIGNATURE <i>S. Borssuck</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/16/66			
22c. PHYSICIAN'S NAME (Type) S. Borssuck, M.D.						22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/16/1966		23c. NAME OF CEMETERY OR CREMATORY DAVIDSONVILLE METH. CEM.				23d. LOCATION (City, town or county) (State) DAVIDSONVILLE A.A.CO. MD.			
24. FUNERAL DIRECTOR <i>Charles E. Hopping</i> HOPPING FUNERAL HOME						25a. REC'D BY REGISTRAR APR 18 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1917

NEW YORK

1917

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your machine. I will try to get it fixed for you as soon as possible.

I am, Sir, very respectfully,
Yours truly,
J. H. [Name]

Enclosed for you are the bills for the work done on your machine.

I am, Sir, very respectfully,
Yours truly,
J. H. [Name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>												
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Mary</i> Last <i>Aist</i>			4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1966</i>			5. SEX <i>F</i>			6. COLOR OR RACE <i>W</i>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>April 17, 1891</i>			9. AGE (In years last birthday) <i>75</i> yrs. <table border="1"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months Days	Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Peter Delancey Robinson</i>						14. MOTHER'S MAIDEN NAME <i>Annie Delaney</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>						16. SOCIAL SECURITY NO.		17. INFORMANT <i>George R. Best</i> Address <i>Huntingtown Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Left Ventricular Failure</i> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Centenarian Heart Disease & Chronic Tuberculosis</i> DUE TO (c) <i>approx 5-6 months</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hyperthyroidism</i>												
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>4-27</i> , 19 <i>66</i> , to <i>4-29</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4-29</i> , 19 <i>66</i> , and that death occurred at <i>4:50</i> AM, from the causes and on the date stated above.												
22a. SIGNATURE <i>H. T. O'Herlihy</i>						22b. DATE SIGNED <i>4-29-66</i>			22c. PHYSICIAN'S NAME (Type) <i>H. T. O'HERLIHY M.D.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>5-2-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore Maryland</i>		
24. FUNERAL DIRECTOR <i>Willie Donaldson Laurel Md.</i>						25a. REC'D BY REGISTRAR <i>MAY 5 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

10/10/79

10/10/79 10:10 AM

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 2, 7 Film 6575 4/21/66 mh

04663

CERTIFICATE OF DEATH

04663

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Unknown Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unknown/ Catonsville</u>	
c. LENGTH OF STAY IN lb <u>40 Years</u>		d. STREET ADDRESS <u>Unknown 6 Jones Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>#02292 Minnie Anderson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898</u>
9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>442x</u> IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive Arteriosclerotic Cardiovascular</u> DUE TO <u>Renal Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypostatic Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>66</u> , to <u>4/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>66</u> , and that death occurred at <u>4:45</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Charles J. Henry</u>		22b. DATE SIGNED <u>4/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Hupp, M.D.</u>		22d. ADDRESS <u>Crownsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-11-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Laurel Md.</u>	23d. LOCATION (City or Town) (County) (State) <u> </u>
24. FUNERAL DIRECTOR <u>William Rose II 108 W. Washington Ave.</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Henry</u>		25c. REGISTRAR'S NAME <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-10-1914

RECEIVED BY MAIL

UNITED STATES

TO THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.
FROM THE
BUREAU OF LAND MANAGEMENT
SALT LAKE CITY, UTAH
SUBJECT: [Illegible]

Very respectfully,
[Illegible Signature]

CERTIFICATE OF DEATH

04664

04664

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Shady Side	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE ELLEEN		4. DATE OF DEATH April 18 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1893	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) 72 yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry Bell		14. MOTHER'S MAIDEN NAME IDA V. Sheiblein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT WM ARMOUR, Shadyside, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto myocardial infarct 4201 DUE TO (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myxedema.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (has has) attended the deceased from March 5 , 19 66 , to April 18 , 19 66 that (I) (was was) saw the deceased alive on April 18 , 19 66 , and that death occurred at — M, from causes and on the date stated above.			
22a. SIGNATURE James O'Brien		22b. DATE SIGNED 4/18/66	
22c. PHYSICIAN'S NAME (Type) GORMAN - CHURCH		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 21, 1966	
23c. NAME OF CEMETERY OR CREMATORY DeWitt Ridge		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR T A Hardisty 12 Ridgely Ave Annapolis, Md		25a. REC'D BY REGISTRAR APR 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

04665

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04665

1. PLACE OF DEATH a. COUNTY <u>ALCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DON - North AKUNDL - Hosp</u>				d. STREET ADDRESS <u>Center & Kennedy Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LORRAINE</u> Middle <u>Baby</u> Last <u>LOW</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1911</u>	9. AGE (in years lost birthday) yrs <u>54</u>	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>		11. IF UNDER 24 HRS Hours <u>17</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Ludwig</u>				14. MOTHER'S MAIDEN NAME <u>Mr. Clair D. Babylon (Husband)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Sam Astor</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Churne</u> 7344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Shocks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF DEATH Hour <u>19</u> m. <u>00</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. H. H. H.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>F-17-CC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, MD.</u>	
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		ADDRESS <u>519 Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04666

04666

1 PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admiss on) a. STATE <u>MARYLAND.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>D.O.A. - North. Arundel - Hosp.</u>		d. STREET ADDRESS <u>22 M. Haley - Neck - Road.</u>	
3 NAME OF DECEASED (Type or print) First <u>Edward.</u> Middle <u>M.</u> Last <u>Ballman</u>		4 DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 10, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Same Operator (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>United Iron & Metal Co.</u>	9 AGE (In years last birthday) yrs <u>63</u>
11 BIRTHPLACE (State or foreign country) <u>Brooklyn, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Frank Ballman</u>		14 MOTHER'S MAIDEN NAME <u>Mary Schultz</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv. co.) <u>No</u>		16 SOCIAL SECURITY NO. <u>313-07-7344</u>	
17 INFORMANT <u>Mrs. Ellen M. Ballman (wife)</u>		Address <u>Same As 12</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V. Disease</u> <u>1221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Due to</u>			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, A.A.Co., Md.</u>
24 FUNERAL DIRECTOR <u>R.V. Singleton</u>		25a. RECD BY REGISTRAR <u>APR 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04667

CERTIFICATE OF DEATH

04667

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 48 Market Place	
3 NAME OF DECEASED (Type or print) 3-# Frank First Middle Last		4. DATE OF DEATH Month 4 Day 23 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1921
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Baskes		14. MOTHER'S MAIDEN NAME Sophie Baskes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 3221 IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Chronic Alcoholism DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) Acute Brain Syndrome Secondary to Alcoholic Intoxication			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/21 , 19 66 to 4/23 , 19 66 , that (I) (we) last saw the deceased alive on 4/23 , 19 66 , and that death occurred at 5:30 A.M., from causes and on the date stated above			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 4/27/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 5/3/66	23c. NAME OF CEMETERY OR CREMATORY Univ. of Maryland	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Rouse		25a. REC'D BY REGISTRAR DATE MAY 5 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04668

CERTIFICATE OF DEATH

04668

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b North Arundel Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 7839 Americana Circle Apt 102 e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last BAUER *SR.				4. DATE OF DEATH Month April Day 30 Year 1966			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 March 1904	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative Pide-Piper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Bauer				14. MOTHER'S MAIDEN NAME Susa Sauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-01-7015		17. INFORMANT Address Lillian L. Bauer - Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Disease DUE TO (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1-3 hr 5-6 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1946 , to 4/30 , 1966 , that (I) (we) last saw the deceased alive on 4/30 , 1966 , and that death occurred at 10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles L. Ball				22b. DATE SIGNED 4/30/66		22c. PHYSICIAN'S NAME (Type) Charles L. Ball	
22d. ADDRESS 203 W. Maple Road, Linthicum, Md.				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR R. V. Singleton				24a. ADDRESS Singleton Funeral Home/ Glen Burnie, Md.		24b. REC'D BY REGISTRAR MAY 3 1966	
24c. REGISTRAR'S SIGNATURE Charles Judge							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04669

04669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Benfield Rd.,</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Benfield</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>William Montgomery Beall</u>		4. DATE OF DEATH <u>April 26, 1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 6, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret- well digger</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Well Drilling</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas O. Beall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hammond</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-12-9012</u>		17. INFORMANT <u>Box 104 Mr. George Beall-son Crownsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Few</u> DUE TO (c) <u>Ca of months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 51</u> 1962 to <u>April 26</u> 1966 , that (I) (we) last saw the deceased alive on <u>April 26</u> 1966 , and that death occurred at <u>9 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Robert Dabolins</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>400 Gann Hwy, New Glen, Boring, Md.</u>				22b. DATE SIGNED <u>4-28-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT DABOLINS, M.D.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Apr. 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Mem. Cemetery</u>				23d. LOCATION (City, town or county) <u>Millersville, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin L. Hopper</u> ADDRESS <u>1011 G. F. L. Rd. - Annapolis, Md.</u>								25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>APR 29 1966</u> <u>Charles Judge</u>							

04670

CERTIFICATE OF DEATH

04670

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN lb <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>55 Amos Garrett Boulevard</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Stehle BEAN</u>				4. DATE OF DEATH Month Day Year <u>April 30 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1906</u>		9. AGE (In years last birthday) <u>60 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES J. STEHLE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE SPRIGGS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS CLIZABETH BEANS 117 SPALLOW AVE 2A-C</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>April 30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>April 29</u> 19 <u>66</u> , and that death occurred at <u>4:30 AM</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John L. Hedeman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <u>5:30 AM</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman, M.D.</u>				22d. ADDRESS <u>1407 Forest Drive, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-2-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR & SONS</u>				ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			



1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04671

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H. H. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. CHAIRE</u> 02-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>RT #4</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES J. BENDA</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1924</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RETO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOSEPH BENDA</u>				14. MOTHER'S MAIDEN NAME <u>HILDA NEUMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>217-14-7433</u>		17. INFORMANT <u>MARGARET L. BENDA</u> #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Disease</u> 4344 DUE TO (b) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Failure</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>4/30/66</u>							
ACTUAL SIGNATURE <u>E. Linhorst</u> EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>JOHN M TAYLOR SOWS ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04672

CERTIFICATE OF DEATH

04672

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN To 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Port Street 724,	
3. NAME OF DECEASED (Type or print) #31597 Edward Bennett		4. DATE OF DEATH Month 4 Day 3 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/06
9. AGE (In years and birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if not real) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Bennett		14. MOTHER'S MAIDEN NAME Carrie Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 7/4/42 9/20/43		16. SOCIAL SECURITY NO. 216-01-0438	
17. INFORMANT Mr. Lawrence Taylor Hospital Records 724 N. Port St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/21/1966, to 4/3/1966, that (I) (we) last saw the deceased alive on 4/3/1966, and that death occurred at 6:05 P.M. from causes on and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 4/4/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/8/66	23c. NAME OF CEMETERY OR CREMATORY Baltimore Maryland	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. Baltimore Md.		25a. REC'D BY REGISTRAR APR 11 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04673										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					d. STREET ADDRESS <u>Bells Trailer Park</u>					
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>OLIE</u> Last <u>Bestland</u>					4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-75</u>		9. AGE (in years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARNIVAL OWNER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AMUSEMENT</u>			11. BIRTHPLACE (County & State, or foreign country) <u>GRANITE FALLS MINN.</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>255-22-9310</u>		17. INFORMANT <u>HARRY L. BESTLAND -</u>			Address <u>Box 26 KERRILL</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>491X</u> DUE TO (b) <u>Pt. pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Primary pneumonia</u>									INTERVAL BETWEEN ONSET AND DEATH <u>12 day</u> <u>12 day</u> <u>12 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>66</u> , to <u>4/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>5:06 A</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Elvis L. Fink</u> M.D.								22b. DATE SIGNED <u>4/12/66</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>4/15/66</u>		<u>Glen Haven</u>			<u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>					ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10-21 Film 327
8-10-66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04674

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b Linthicum Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL				e. STREET ADDRESS CHEDDINGTON ROAD 311 CHEDDINGTON Road			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA A. BOCK				4. DATE OF DEATH Month Day Year April 19 19 66			
SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 21, 1932		9. AGE (In years lost birthday) yrs 33	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE CO. MARYLAND		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH KLEIN				14. MOTHER'S MAIDEN NAME OLGA REISLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-30-0774		17. INFORMANT MR. GEORGE S. BOCK, JR. 311 CHEDDINGTON RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure and cardiac arrest DUE TO during a convulsive seizure of unknown etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 4-19-66	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-22-66		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229				25a. REC'D BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

04675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ADCO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MD b COUNTY ADCO	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODEUNTON		c LENGTH OF STAY IN TOWN	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kinbrough Army Hospital		e STREET ADDRESS 444 Telegraph Road	
3 NAME OF DECEASED (Type or print) Becky Mae Bauman		4 DATE OF DEATH Month April Day 24 Year 1966	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Apr. 21 - 1938
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Margantown, W. Va		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James R. Bauman		14 MOTHER'S MAIDEN NAME Theodora Metz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service no		16 SOCIAL SECURITY NO	
17 INFORMANT William Bauman, Margantown, W. Va.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Y254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) Auto accident R 175	
20c TIME OF INJURY Month Day Year 4/24 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Road 175	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State) ADCO MD	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. W. H. H. H.		22. DATE SIGNED 4/24/66	
EXAMINER'S NAME (Type) E. L. W. H. H. H.		23a LOCATION (City or Town) (County) (State) Truckee Co. W. Virginia	
23b. DATE THEREOF 4-27-66		23c NAME OF CEMETERY OR CREMATORY St George Cem.	
23d BURIAL, CREMATION, REMOVAL (Specify) Burial		23e ADDRESS Laurel Md	
24 FUNERAL DIRECTOR Delbert Donaldson		25a REC'D BY REGISTRAR APR 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

04676

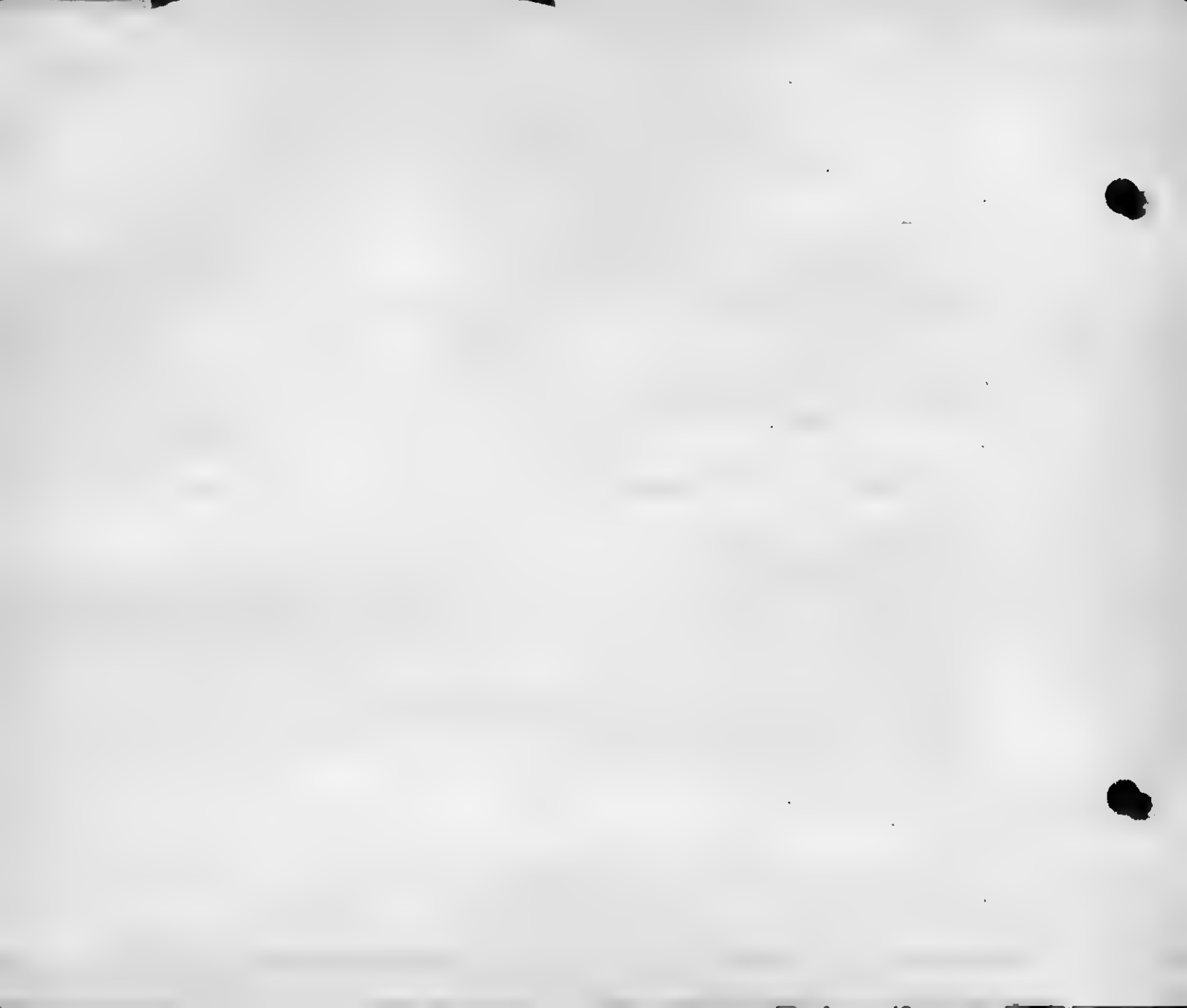
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04676

1. PLACE OF DEATH a. COUNTY <u>A. A.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>98 College Ct. Terrace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Boyd</u>		4. DATE OF DEATH <u>4-11-1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1923</u>
9. AGE (In years last birthday) <u>42</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Emma Boyd</u>		Address <u>98 College Ct. Terrace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis C V disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Inghart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Inghart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-16-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR <u>William Reese #</u>		24. REC'D BY REGISTRAR <u>Charles Judge</u>	
24. REGISTRAR'S SIGNATURE		DATE <u>APR 15 1966</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04677

Item 7 Film 3512 4/13/66

CERTIFICATE OF DEATH

04677

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Malone 69.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 34 4th St.	
3. NAME OF DECEASED (Type or print) First Middle Last Anne Cooney BRENNAN		4. DATE OF DEATH Month Day Year April 10 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1899
9. AGE (In years lost birthday) yrs 67 66		10. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ANDREW B COONEY		14. MOTHER'S MAIDEN NAME ELIZABETH FERRELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MR. JOHN F. COONEY		Address 1000 VERMONT AVE. WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1966 , to April 10, 1966 , that (I) (we) last saw the deceased alive on April 10, 1966 , and that death occurred at 7:35 PM M. from causes and on the date stated above.			
22a. SIGNATURE J. M. SHIPLEY		22b. DATE SIGNED 4-11-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-14-1966	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH CEM.		23d. LOCATION (City or Town) (County) (State) MALONE N.Y.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD		25a. REC'D BY REGISTRAR APR 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>04678</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>04678</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>AN -</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Brunel Ho</u>						d. STREET ADDRESS <u>Queens town Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>—</u> Last <u>BROOKS</u>						4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-04</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Cty.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Adelaide Egan Harmon Md</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> <u>Constrictive Heart Failure</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>66</u> , to <u>4/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Wayne B. Tate</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Wayne B. Tate, M.D.</u>						22d. ADDRESS <u>108 Central Ave., N.W. (G.B.)</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>4-16-66</u>		<u>St. Calvary</u>		<u>Brooklyn Pa to Md</u>					
24. FUNERAL DIRECTOR <u>Turnell B. Oden - Balto. Md</u>						25a. REC'D BY REGISTRAR DATE <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04679
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 35 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Box 534 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPHINE ALVERTA BROWN		4. DATE OF DEATH April 14 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8 -1899
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11b. KIND OF BUSINESS OR INDUSTRY *****	
12. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Albert Brown		15. MOTHER'S MAIDEN NAME Virginia Alton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 219-26-2005	
18. INFIRMITY Albert A. Brown-Arnold, Maryland A.A.Co.		19. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Corbore failure DUE TO (b) Heart 2 yrs DUE TO (c) Interval BETWEEN ONSET AND DEATH CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19, to 4-15-66 , 19, that (I) (we) last saw the deceased alive on 4-11-66 , 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE A.T. Allen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A.T. Allen		22d. ADDRESS Cathedral St. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 17-66	
23c. NAME OF CEMETERY OR CREMATORY Pine Lawn		23d. LOCATION (City, town or county) (State) Bestgate Rd. Annapolis, Md.	
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.		25a. REC'D BY REGISTRAR APR 19 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04680 CERTIFICATE OF DEATH 04680

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>F.</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1890</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LEVIN P. KELLY</u>		14. MOTHER'S MAIDEN NAME <u>JULIA O'HARA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ROHARD A. BROWN #2</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease, 2 mitral insufficiency + aortic stenosis.</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1964</u> to <u>April 1966</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> 1966, and that death occurred at <u>12A</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>J. White</u>		22b. DATE SIGNED <u>4/11/66</u>		22c. PHYSICIAN'S NAME (Type) <u>MD</u>	
22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	
23d. LOCATION (City, town or county) <u>ANNAPOLIS</u>		23e. (State) <u>MD.</u>		23f. REC'D BY REGISTRAR <u>APR 13 1966</u>	
23g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23h. ADDRESS <u>ANNAPOLIS, MD</u>			

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ZOM 1/65

1 (M)

04681

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04681

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CRANNSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CRANNSVILLE STATE HOSPITAL</u>				d. STREET ADDRESS <u>222 BELEVER AV</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>BROWN</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1966</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/19/1915</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
1da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		1db. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>WILLIAM MIREHEAD</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE GREEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CENTRAL NERVOUS SYSTEM DYPHILLIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/13/66</u> , 19 <u> </u> to <u>4/18/66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4/18/66</u> , 19 <u> </u> , and that death occurred at <u>510A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Hollis Seunarine, M.D.</u>				22b. DATE SIGNED <u>4/18/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE</u>				22d. ADDRESS <u>CRANNSVILLE STATE HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles A. Rue 661 W. Bane St.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1870
1871

1872
1873
1874
1875
1876
1877
1878
1879
1880
1881
1882
1883
1884
1885
1886
1887
1888
1889
1890
1891
1892
1893
1894
1895
1896
1897
1898
1899
1900

1901

1902

1903

1904
1905
1906
1907
1908
1909
1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

04682

CERTIFICATE OF DEATH

04682

1 PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 10 days		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 286 West St.	
3 NAME OF DECEASED (Type or print) William Edward BROWN		4. DATE OF DEATH Month April		Day 15		Year 19 66			
5 SEX Male		6 COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1903		9 AGE (In years last birthday) 62 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckers Helper		10b. KIND OF BUSINESS OR INDUSTRY *****		11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13 FATHER'S NAME John Wesley Brown				14 MOTHER'S MAIDEN NAME Annie Simms					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-0701		17. INFORMANT Address Ruby P. Brown-286 West St. Anna. Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute cardiac failure 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 15, 1966 , to April 15, 1966 , that (I) (we) last saw the deceased alive on April 15, 1966 , and that death occurred at 4:16 P.M. M, from causes and on the date stated above									
22a. SIGNATURE A T ALLEN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-16-66					
22c. PHYSICIAN'S NAME (Type) A T ALLEN		22d. ADDRESS 6 L. Behrman Dr							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 20-66		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn		23d. LOCATION (City or Town) (County) (State) Bestgate Rd. Annapolis, Md.			
24 FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR APR 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04683											
1. PLACE OF DEATH a. COUNTY <u>AA Co</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ernest Preston Catterton</u> First Middle Last						4. DATE OF DEATH <u>April 29</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1902</u>		9. AGE (in years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (County & State, or foreign country) <u>A.A. Co., Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Ernest Albert Catterton</u>						14. MOTHER'S MAIDEN NAME <u>Annie Elizabeth Stallings</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218.36.3093</u>		17. INFORMANT <u>Carrie B. Catterton, Bristol</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> <u>157X</u> DUE TO <u>Carcinoma head of pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>12 mos</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>46</u> to <u>24 Apr</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>29 Apr</u> 19 <u>66</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>May 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>			23d. LOCATION (City, town or county) (State) <u>Lothian, Md</u>		
24. FUNERAL DIRECTOR <u>T S Hardesty + Son, Gaesville, Md</u>						25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04684

CERTIFICATE OF DEATH

04684

1. PLACE OF DEATH a. COUNTY <u>Prince Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna</u>		
c. LENGTH OF STAY IN ID <u>4 days</u>		d. STREET ADDRESS <u>203 Delmont Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>M.</u> Last <u>Clock</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-74</u>	
9. AGE (in years last birthday) <u>91</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George H. Tase</u>		14. MOTHER'S MAIDEN NAME <u>IDA P. GRIFF</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-54-9800</u>		
17. INFORMANT <u>DORIS ITALUODA</u>		Address <u>SAME AS #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 1024 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>66</u> to <u>4/1</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>66</u> , and that death occurred at <u>8:59</u> P.M. from the causes and on the date stated above.				
22a. SIGNATURE <u>Wayne B. Tate MD</u>		22b. DATE SIGNED <u>4/1/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>WAYNE B. Tate MD</u>		22d. ADDRESS <u>108 Central Ave</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 5, 1966</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Severna Md.</u>		
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>		
25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06325

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>California</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garden Grove</u> d. STREET ADDRESS <u>9101 LeGrange Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KENT</u> Middle <u>C.</u> Last <u>CODY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 66</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 13, 1946</u>	
9. AGE (In years IF UNDER 1 YEAR last birthday) <u>20</u> yrs. Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min.		10. BIRTHPLACE (State or foreign country) <u>California, Long Beach</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Roland Cody</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen Carrier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Active 558-64-0377</u>		16. SOCIAL SECURITY NO. <u>U.S. Army Records</u>	
17. INFORMANT <u>U.S. Army Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Hemothorax</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of Aorta.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto-auto accident.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4/30 1966</u> Hour <u>XXX</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Annapolis</u> (County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cemetery & Mausoleum, 4400 Cherry Ave., Long Beach California</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Harold S. Wade, Lincell, Maryland</u>		24a. REC'D BY REGISTRAR <u>Charles Judge</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>MAY 10 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

(M)

04686

MARYLAND STATE DEPARTMENT OF HEALTH

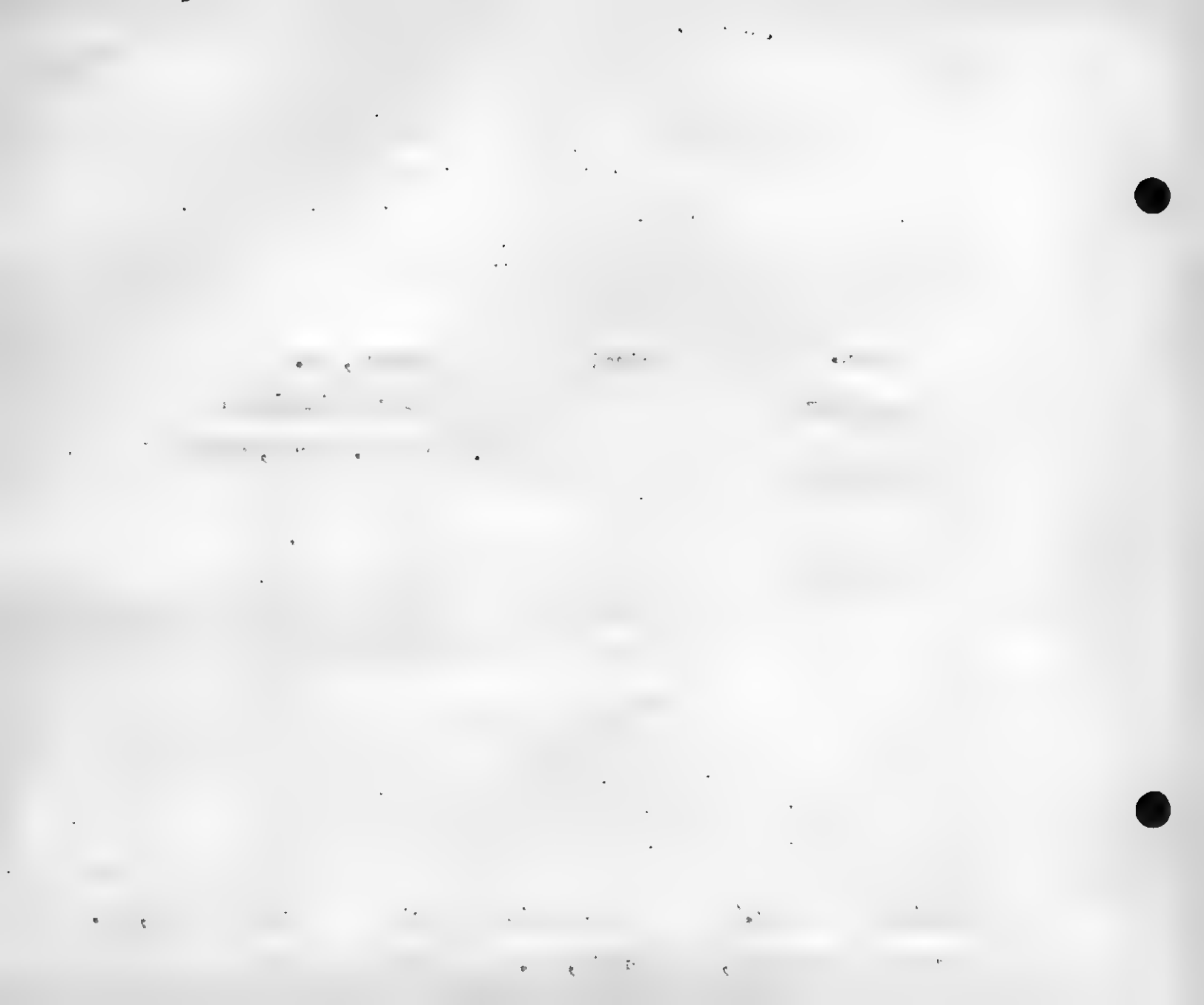
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04685

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i> c. LENGTH OF STAY IN 1b <i>1 WEEK</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>North Howard Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i> d. STREET ADDRESS <i>1225 Guilford Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>William</i> Middle <i>E.</i> Last <i>CONRAD</i>		4. DATE OF DEATH <i>4-2-1966</i>		5. SEX <i>m</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-2-03</i>		9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>T V Tech</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Sunbury, Pa.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Jasper Conrad</i>								14. MOTHER'S MAIDEN NAME <i>Clara Heintzleman</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>				17. INFORMANT Address <i>Mrs. Dortha R. Conrad, same as 2</i>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>Diabetes Mellitus</i> DUE TO (c) <i>Gastro-intestinal hemorrhage</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>weeks</i> <i>1/2 hour</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>3/26, 1966</i> to <i>4/2, 1966</i> that (I) (we) last saw the deceased alive on <i>4/2, 1966</i> , and that death occurred at <i>8:00 PM</i> , from the causes and on the date stated above.																			
22a. SIGNATURE <i>Max C Frank MD</i>																22b. DATE SIGNED <i>4/2/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>MAX C FRANK MD</i>																22d. ADDRESS <i>425 SE Ritchie Hwy-Glen Burnie</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6 Apr. 66</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>				23d. LOCATION (City, town, or county) (State) <i>Howard County, Md.</i>							
24. FUNERAL DIRECTOR ADDRESS <i>Kirkley Funeral Home, Glen Burnie, Md.</i>																			
25a. REC'D BY REGISTRAR <i>APR 6 1966</i>																25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
046887									
04686									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8 1st. Ave.					d. STREET ADDRESS 8 1st. Ave.				
3. NAME OF DECEASED (Type or print) First John Middle T. Last Cooke					4. DATE OF DEATH Month April Day 23 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1898		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner		10b. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Clinton Cooke					14. MOTHER'S MAIDEN NAME Lucy Dunn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. # 1		17. INFORMANT Mrs. Anna E. Cooke		
							Address 8 1st. Ave. 25		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yr. +	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1964 to April 23, 1966 , that (I) (we) last saw the deceased alive on 4-22 1966 , and that death occurred at 4 A.M. from the causes and on the date stated above.									
22a. SIGNATURE A.C. SOLLER								22b. DATE SIGNED 4-25-66	
22c. PHYSICIAN'S NAME (Type) A.C. SOLLER								22d. ADDRESS 707 E. FORT AVE - 30	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 26 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City, town or county) (State) Brooklyn, A. A. Co. Md.		
24. FUNERAL DIRECTOR Mc Cully				ADDRESS 130 E. Fort Ave		25a. REC'D BY REGISTRAR APR 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

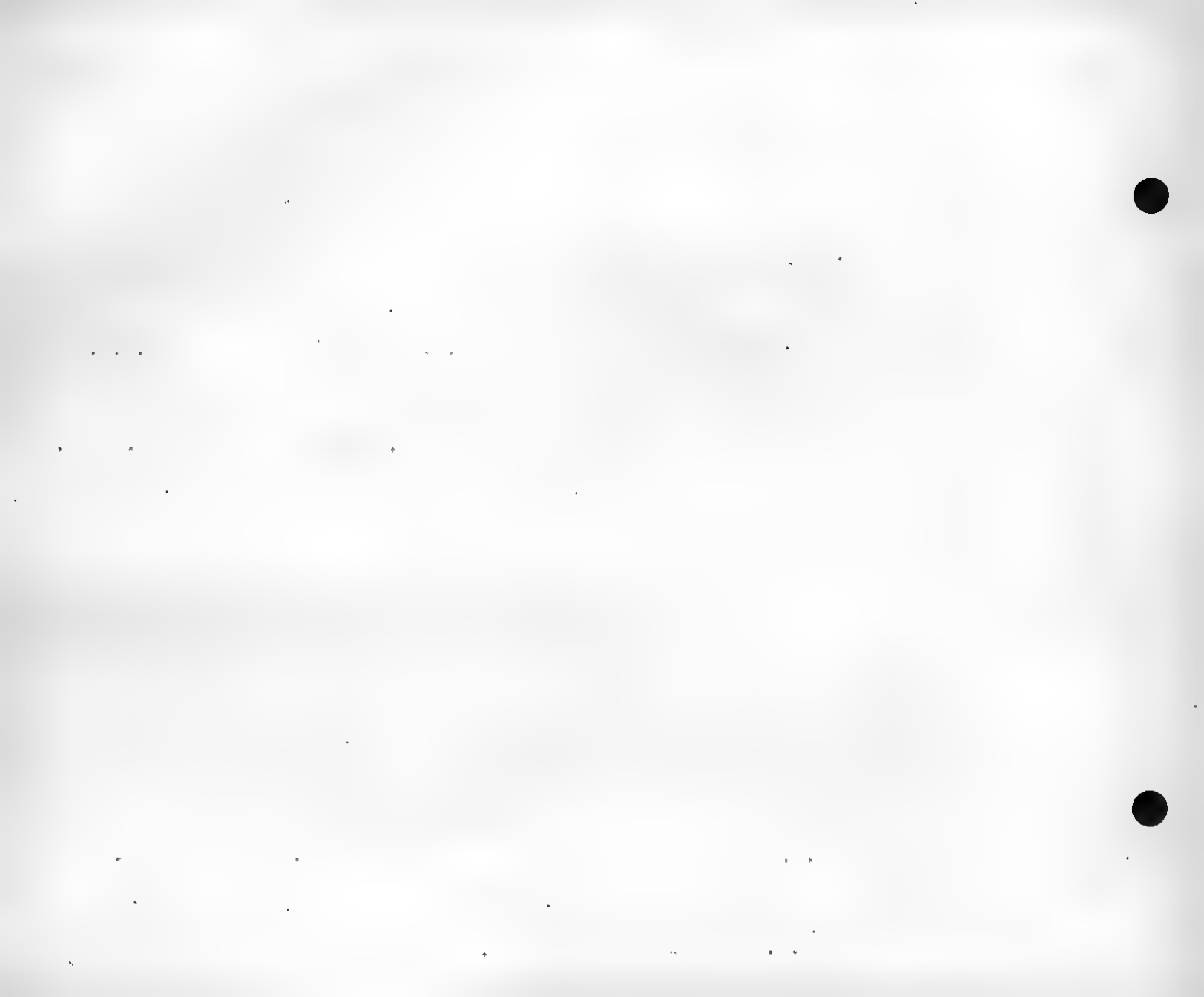
04687

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
c. LENGTH OF STAY IN 1b 2 YEARS				d. STREET ADDRESS APT. D 7493 FURNACE BRANCH ROAD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7493 FURNACE BRANCH ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARIE M. Curran				4. DATE OF DEATH Month Day Year 4 4 1966			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 16, 1894	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) ANNE ARUNDEL CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWNHOME			
13. FATHER'S NAME FRANK P. CURRAN				14. MOTHER'S MAIDEN NAME BARBARA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS MARY L. CURRAN (SISTER)		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chloroform poisoning</i> 4500 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. L. Singleton</i>				22. DATE SIGNED 4/4/66			
EXAMINER'S NAME (Type) E. L. Singleton				M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 7, 1966		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town or county) (State) BROOKLYN, R.F.D. MD.	
24. FUNERAL DIRECTOR R.V. SINGLETON				25a. RECEIVED BY REGISTRAR APR 11 1966			
ADDRESS GLEN BURNIE, MD.				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4 should be filed with the State Dept. of Health within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04689 CERTIFICATE OF DEATH 04688									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN ID life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 608 - First Street					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 608 - First Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GEORGE WASHINGTON DAVIS					4. DATE OF DEATH April 13 1966				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12-1894		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate - self Employed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Virgle Davis					14. MOTHER'S MAIDEN NAME Mary Peale				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 220-32-3141		17. INFORMANT Virginia D. Bryant-606 Second St. Anna. Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH about 9 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1957 to 4-12 1966 , that (I) (we) last saw the deceased alive on 4-12 1966 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.									
22a. SIGNATURE A.T. Allen						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A.T. Allen						22d. ADDRESS Cathedral St. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF April 16-66		23c. NAME OF CEMETERY OR CREMATORY Annapolis - Neck		23d. LOCATION (City, town or county) (State) Annapolis, Maryland		
24. FUNERAL DIRECTOR C.E. Hicks ADDRESS 111 Annapolis, Md.						25a. REC'D BY REGISTRAR APR 19 1966 DATE		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



04630

CERTIFICATE OF DEATH

04689

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 24 Riverdale Drive	
3. NAME OF DECEASED (Type or print) First Esther Middle Last DELGADO		4. DATE OF DEATH Month April Day 10 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1925
9. AGE (In years last birthday) yrs. 40		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERTO DELGADO		14. MOTHER'S MAIDEN NAME CONCEPTION PARADIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT DR GUSTAVE DELGADO # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Melanotic carcinoma of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (doctor) attended the deceased from October , 19 65 , to April 10, 1966 , that (I) (doctor) saw the deceased alive on April 10 , 19 66 , and that death occurred at 3:05 AM , from causes and on the date stated above.			
22a. SIGNATURE General Blumel		22b. DATE SIGNED 4/11/66	
22c. PHYSICIAN'S NAME (Type) Berman et al.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-12-1966	
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS		25a. DECEASED BY REGISTRAR APR 13 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

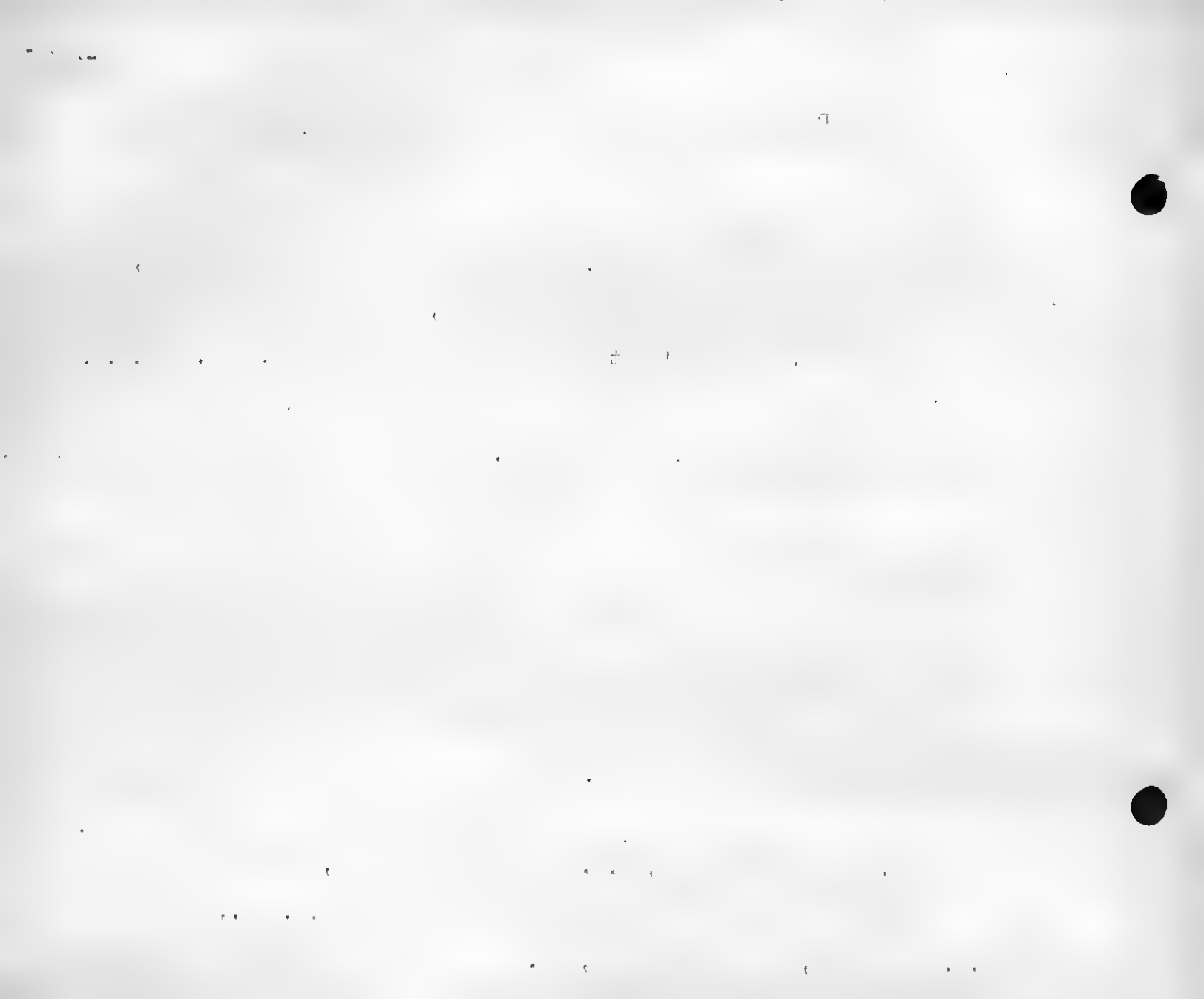
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04691 CERTIFICATE OF DEATH 04690									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #510 Shipley Road					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum d. STREET ADDRESS #510 Shipley Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JULIET C. DISNEY			4. DATE OF DEATH April 17, 1966						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1895		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (ret.)			10b. KIND OF BUSINESS OR INDUSTRY Dep't Store		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Fulton Kelly				14. MOTHER'S MAIDEN NAME Nettie Clark					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 212 28 6860		17. INFORMANT Mr. Robert Weldon Disney (son) Address Balto., Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 2 hrs several years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 2, 1966 to April 17, 1966 , that (I) (we) last saw the deceased alive on April 17, 1966 , and that death occurred at 7:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE E. Roderick Shipley				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 18, 1966			
22c. PHYSICIAN'S NAME (Type) E. Roderick Shipley, M.D.				22d. ADDRESS Linthicum, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 20/66		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City, town or county) (State) A.A. Co., Maryland			
24. FUNERAL DIRECTOR R.V. Singleton,				25a. REC'D BY REGISTRAR APR 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04692					04691				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE				
Anne Arundel MARYLAND					MD				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Annapolis 7 days					Annapolis Md				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Anne Arundel Gen Hosp					1203 Poplar St.				
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month Day Year	
Emma Agnes Dammeyer						4-10-66		19	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-28-93		73 yrs.		Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Home		Germany		U.S.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN SOTENSHKEK					MARIE PORICK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO					Ralph Dammeyer #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 myocardial infarction DUE TO (b) Congestive Heart Failure Grade IV DUE TO (c) A-E.V.D.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956, 1955, to 1966, 19, that (I) (we) last saw the deceased alive on 4-10-66, and that death occurred at 6 AM, from the causes and on the date stated above.									
22a. SIGNATURE Robert R. Halper M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-10-66
22c. PHYSICIAN'S NAME (Type) Robert R. HALPER					22d. ADDRESS P.O. Box 73 Severna Park				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		4-13-66		CEDAR BLVD		ANNAPOLIS, MD.			
24. FUNERAL DIRECTOR John M. Taylor					ADDRESS Annapolis, Md.		25a. RECORD BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. and in any event within 72 hours after death.

Items 1-21 Film G376 5/ MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 2 Film G376 5/6/66 mh Item 18a Film G377 3/26/66 IT											
04693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH						04692					
1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland Pa. Del.					
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c LENGTH OF STAY in lb		c CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Laurel Newtown Square				d STREET ADDRESS 218 4th Ave. Barn 177 Laurel Stables	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) North Arundel Hospital						e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First (John Lionel Danby) Last Donly						4 DATE OF DEATH Month 4 Day 29 Year 1966					
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 25, 1917		9 AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 29 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) groom				10b. KIND OF BUSINESS OR INDUSTRY thoroughbred racing		11 BIRTHPLACE (State or foreign country) Newtown Square, Penna.				12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Danby						14. MOTHER'S M A DEN NAME Martha A. Westgarth					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 164-16-1820		17 INFORMANT Mrs. Jennie Stone Address 218 4th Ave, Newtown Sq, Pa					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal cortical hemorrhages (b) following cellulitis (c) (dog bite-by history -of thigh)										INTERVAL BETWEEN ONSET AND DEATH 41.29	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bitten by dog											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Bitten by dog							
20c. TIME OF INJURY Month Day Year hour am ? p.m. 3/30 1966				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home farm, factory, street, office bldg, etc.) ?		20f (City or town) Laurel A. A.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion a death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						22. DATE SIGNED 4/29/66					
23a BURIAL CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 5-3-66		23c NAME OF CEMETERY OR CREMATORY Glenwood Memorial Gardens Marple Township, Pa.				23d LOCATION (City or Town) (County) (State) Pa.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Rd, Balto.						ADDRESS 5305 Harford Rd, Balto.		25a REC'D BY REGISTRAR MAY 3 1966		25b REGISTRAR SIGNATURE Charles Judge	



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04694

04693

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in lb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sherwood Forest Rd.</u>		e. STREET ADDRESS <u>Sherwood Forest Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Franklyn W. Horsey</u>	First Middle Last	4. DATE OF DEATH <u>4-1-1966</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Horsey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-051013</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adv. necd Carcinoma of Stomach with metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>mc 15, '66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/7/66</u> to <u>4/1/66</u> , that (I) (we) last saw the deceased alive on <u>3/31/66</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Johnson M.D.</u>		22b. DATE SIGNED <u>4/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>		22d. ADDRESS <u>20 Dean St. Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-4-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fowler</u>		23d. LOCATION (City, town or county) (State) <u>Best Gate Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 5 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within n 72 hours after death.

VR A15ME (5)
6M 1/66

04695

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film 4/7/66 mb

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04694

1 PLACE OF DEATH a. COUNTY A.A. CO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY A.A. CO.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Glen Burnie.		c. LENGTH OF STAY in lb 6 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 725 Hamlen Rd.		e. STREET ADDRESS 725 Hamlen Road.	
3. NAME OF DECEASED (Type or print) First James Middle T Last Embrey		4. DATE OF DEATH Month 4 Day 1 Year 1966	
5 SEX M.	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 Aug. 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Highway Emp.		10b. KIND OF BUSINESS OR INDUSTRY Retired	9 AGE (In years last birthday) 75 7/76 yrs
11 BIRTHPLACE (State or foreign country) Delaplane, Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Embrey		14. MOTHER'S MAIDEN NAME Alice Cary Costello	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 230-30-7555	
17. INFORMANT Mrs. Vera Embrey, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerosis general 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. Hardt M.D.		22. DATE SIGNED 4/1/66	
EXAMINER'S NAME (Type) E. L. Hardt		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 5, 1966	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Upperville, Va.
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR APR 4 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

04696

CERTIFICATE OF DEATH

04695

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN Tb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 803 Dreams Landing	
3. NAME OF DECEASED (Type or print) First John Middle Conrad Last EYSTER		4. DATE OF DEATH Month April Day 13 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1898
9. AGE (in years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JEWELER RET.		10b. KIND OF BUSINESS OR INDUSTRY JEWELRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERT EYSTER		14. MOTHER'S MAIDEN NAME ANNA M. GRATZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. FRANCES R. EYSTER # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5400 IMMEDIATE CAUSE (a) Bleeding duodenal ulcer. DUE TO (b) Peptic ulcer. DUE TO (c) Reflex ulcer. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 years.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema, coronary atherosclerosis & peripheral vascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) did not attended the deceased from April 13 , 19 66 , to Apr. 13 , 19 66 , that (I) was saw the deceased alive on Apr. 13 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE General Charles		22b. DATE SIGNED 2:45 PM 4-14-66	
22c. PHYSICIAN'S NAME (Type) General Charles		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/16/1966	23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEMORIAL CEMETERY	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.		25. REC'D BY REGISTRAR APR 15 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04697 CERTIFICATE OF DEATH 04696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN lb 18 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 426 Crain Highway S. W.				d. STREET ADDRESS 426 Crain Highway S. W.			
3. NAME OF DECEASED (Type or print) Helen Bertha Fink				4. DATE OF DEATH Month April Day 30 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/1892	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73		IF UNDER 24 HRS. Hours 73 Min. 73		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Chesterfield, Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thaddeus Crump				14. MOTHER'S MAIDEN NAME Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 215-01-3350			
17. INFORMANT Raymond C. Fink				Address 426 Crain Highway S.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Malignant lymphoma							
DUE TO							
Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis							
DUE TO							
(a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 to April , 1966, that (I) (we) last saw the deceased alive on April 15, 1966 , and that death occurred at 2 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Helen Bertha Fink M.D.				22b. DATE SIGNED 6/30/66			
22c. PHYSICIAN'S NAME (Type) H. T. O'HERLHY MD				22d. ADDRESS 5 Central Ave, Glen Burnie Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/66		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink				25. REC'D BY REGISTRAR MAY 3 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04698

CERTIFICATE OF DEATH

04697

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>				e. STREET ADDRESS <i>#215 Light St. Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Laura</i> Middle <i>N.</i> Last <i>Ford</i>				4. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 25, 1906</i>	
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months <i>60</i> Days <i>19</i> Hours <i>19</i> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>August Linck</i>				14. MOTHER'S MAIDEN NAME <i>Alice Green</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>			
17. INFORMANT <i>Mr. Charles E. Ford, Sr. (Husband)</i>				Address <i>Same As #2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>3 years</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the left breast - 18 months - cured</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/30, 1962</i> to <i>4/19, 1966</i> , that (I) (we) last saw the deceased alive on <i>4/11, 1966</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>R.M. McLaughlin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/19/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin, M.D.</i>				22d. ADDRESS <i>368 Mount Airy Rd. Pasadena, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harvard Memorial Park</i>		23d. LOCATION (City, town or county) (State) <i>Balto., Md.</i>	
24. FUNERAL DIRECTOR <i>R.K. Singleton</i>				ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
				25b. REGISTRAR'S SIGNATURE			

APR 21 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04698
04698
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Shipley</u> Last <u>GALLION</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-1876</u>	
9. AGE in years last birthday <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>B. F. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Flower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mr. Carl Gallion - Severn, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic hypertension C-V Dis</u> 443X DUE TO (b) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>April</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 3</u> , 19 <u>66</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. C. R. MacDonald</u>				22b. DATE SIGNED <u>4-4-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. R. MacDonald</u>				22d. ADDRESS <u>204 Crain Hwy So Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-7-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				25a. REC'D BY REGISTRAR <u>APR 11 1966</u>			
ADDRESS <u>Sylva, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

VR A15 (4)
15M 7-62

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the [redacted] Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04701

CERTIFICATE OF DEATH

04700

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last GENT				4. DATE OF DEATH Month April Day 8 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1895	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70	IF UNDER 24 HRS. Days 70	Hours 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Movie Projectionist (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY Ritz Enterprises		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Gent			
14. MOTHER'S MAIDEN NAME Agnes (unknown)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 215-03-1394				17. INFORMANT Mrs. Mabel M. Gent (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid Artery Rupt Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Baltimore				20g. (County) Maryland			
20h. (State) Maryland				21. I certify that (I) (this hospital) attended the deceased from May 1966 to April 1966 , that (I) (we) last saw the deceased alive on April 8, 1966 , and that death occurred at 7:30 M, from the causes and on the date stated above.			
22a. SIGNATURE C. R. Mac Donald MD				22b. DATE SIGNED 4/11/66			
22c. PHYSICIAN'S NAME (Type) C. R. Mac Donald MD				22d. ADDRESS 204 Grain Hwy. S/W Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 12, 1966			
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION (City, town or county) Baltimore, Maryland			
24. FUNERAL DIRECTOR Richard V. Singleton				25a. REC'D BY REGISTRAR APR 13 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. ADDRESS Glen Burnie, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

M

04702

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04701

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c. LENGTH OF STAY IN 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL GENERAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE #25 d. STREET ADDRESS 402 Creswell Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Marvin Middle G. Last Gentry			4. DATE OF DEATH Month April Day 9 Year 19 66		
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9-1-98 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY CC & S		
11. BIRTHPLACE (County & State, or foreign country) No. Carolina			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Riley Gentry			14. MOTHER'S MAIDEN NAME Mary Jane Martin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 246 03 2169		
17. INFORMANT Family Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3/1/68 , 19 65 , to 4/8 , 19 66 , that (I) (we) last saw the deceased alive on 4/8 , 19 66 , and that death occurred at 7:30 AM, from the causes and on the date stated above. 22a. SIGNATURE Wayne B. Tate MD M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) WAYNE B. TATE 22d. ADDRESS 108 Central Ave 22b. DATE SIGNED 4/9/66 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/12/66 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. 23d. LOCATION (City, town or county) (State) Balto. Md. 24. FUNERAL DIRECTOR McCully Funeral Hm. 237 Patsco Ave. 25a. REC'D BY REGISTRAR APR 13 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

04703

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04702

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN b. <u>Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#202 Willow Lane, S/W</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#202 Willow Lane, S/W</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Blanche Ada Mesnall</u> First Middle Last 4. DATE OF DEATH <u>4 19 1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct-6, 1883</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Lanacoring, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Meyers</u> 14. MOTHER'S MAIDEN NAME <u>Mary Watkinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Phoebe Plomski (daughter)</u> Address <u>Same as #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1944</u> to <u>April 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Charles B. McDaniel M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles B. McDaniel</u> 22b. DATE SIGNED <u>4-19-66</u> 22d. ADDRESS <u>204 Chain Pier S.W. Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Apr. 23/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) <u>Balto. Co., Md.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u> 25. REC'D BY REGISTRAR <u>APR 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04704 CERTIFICATE OF DEATH 04703

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Pk.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4930 Brookwood Rd				d. STREET ADDRESS 4930 Brookwood Rd					
3. NAME OF DECEASED (Type or print) First Theresa Middle V. Last Gourley				4. DATE OF DEATH Month 4 Day 15 Year 1966					
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/30/80			
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME Anton Stapf				14. MOTHER'S MAIDEN NAME Anne Tucker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Family Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1959 , to April 15, 1966 , that (I) (we) last saw the deceased alive on April 15, 1966 , and that death occurred at 6:10 PM , from the causes and on the date stated above.									
22a. SIGNATURE Morton M. Krieger				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 16, 1966			
22c. PHYSICIAN'S NAME (Type) Dr. Morton Krieger M. D.				22d. ADDRESS 5010-A Ritchie Highway					
23a. BURIAL, CREMATION, or other (Specify) Burial		23b. DATE THEREOF 4/18/66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Balto. 29, Md.			
24. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave				ADDRESS		25a. REC'D BY REGISTRAR APR 20 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge									

1
FOR STATE
HEALTH DEPT

04705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04704

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

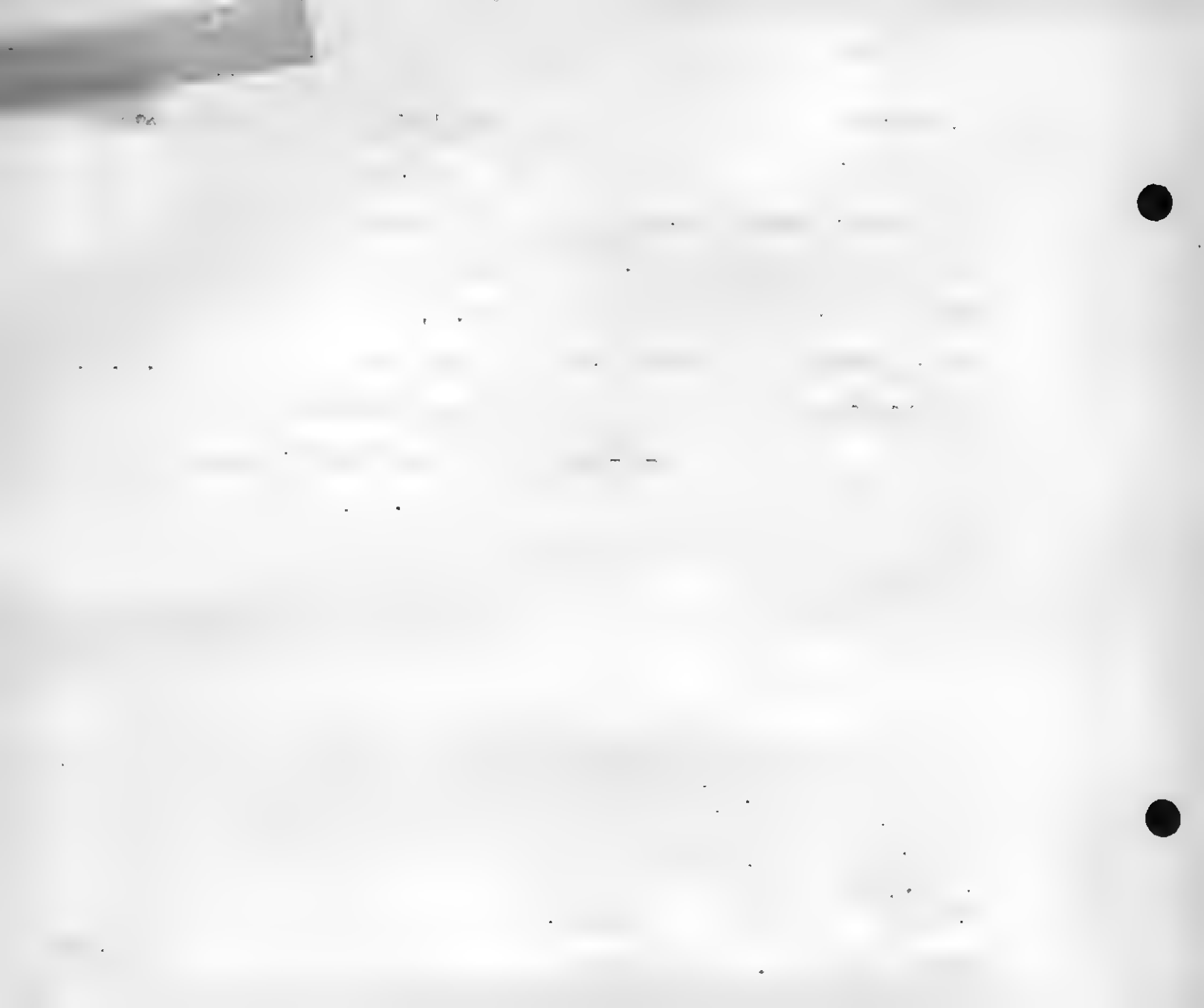
1 PLACE OF DEATH a COUNTY Anne Arundel b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold c LENGTH OF STAY in 1b 1 day d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods off Old Annapolis Rd.		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE MD b COUNTY A. A. Co. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d STREET ADDRESS Box 309 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First AGNES Middle B. Last GREB		4 DATE OF DEATH Month April Day 23 Year 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-27-23
9 AGE (In years last birthday) 42 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk	10b KIND OF BUSINESS OR INDUSTRY Drug Store
11 BIRTHPLACE (State or foreign country) MD		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edward Fieger		14 MOTHER'S MAIDEN NAME Marie Kress	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO Francis J. Geb - Abone	
17 INFORMANT Francis J. Geb - Abone		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wounds of chest and head 981X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot in chest and head	
20c TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. ? 19 66	20d INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods	20f (City or town) (County) (State) Anne Arundel Co.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. Breiteneker M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF 4-27-66	23c NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	23d LOCATION (City, town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Robert S. Baranco		25a REC'D BY REGISTRAR APR 27 1966	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04706 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 626 Annapolis Blvd 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ETHEL		First D		Middle GUMMER		Last GUMMER		4. DATE OF DEATH Month April Day 23 Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1914		9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Data Processing				10b. KIND OF BUSINESS OR INDUSTRY B&O Rail Road		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Daniel					14. MOTHER'S MAIDEN NAME Mary Johnston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-02-9491		17. INFORMANT Mrs Nancy H Tully			Address 626 Annapolis Blvd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of breast DUE TO (c) 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 5 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January, 1966 to April, 1966 , that (I) (we) last saw the deceased alive on April 19, 1966 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Robert A. Gartner					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 23, 1966		
22c. PHYSICIAN'S NAME (Type) ROBERT A. GARTNER					22d. ADDRESS 558 N. Broadway				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/26/66		23c. NAME OF CEMETERY OR CREMATORY Lorraine Maus		23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR Leonard J Ruck Inc.					ADDRESS 5305 Harford Rd		25a. REC'D BY REGISTRAR APR 26 1966 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04772

04771

1 PLACE OF DEATH a. COUNTY <u>HA CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.G.A. - North. HUNDELL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Scull</u> Last <u>AD</u>		4 DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 24 - 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>JOSEPH DARE</u>		14 MOTHER'S MAIDEN NAME <u>CARRIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO.	17. INFORMANT <u>FAMILY</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Tuberculosis - old</u> <u>0081</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic & acute osteoarthritis.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>4.21.66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATL CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>McCULL & F.H. V37</u>		25a. REC'D BY REG. STRAR <u>APR 25 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J.</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04706

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold d. STREET ADDRESS 733 Mill Creek Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last 4. DATE OF DEATH April 17 19 66 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 7, 1927 9. AGE (In years last birthday) 38 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed 10b. KIND OF BUSINESS OR INDUSTRY Glass Co. 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jewel Hankey 14. MOTHER'S MAIDEN NAME May Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO 220 20 2040 17. INFORMANT Mrs. Frances E. Hankey (wife) Same As #2 Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication and Body Burns. 7163 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fire in building.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4/17 1966 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Glass Co. Bldg. 20f. (City or town) Glen Burnie (County) Anne Arundel (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/17/66 Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF April 20, 1966 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park 22d. LOCATION (City, town, or country) Glen Burnie, Maryland 23. FUNERAL DIRECTOR Singleton Funeral Home 24a. REC'D BY REGISTRAR APR 21 1966 24b. REGISTRAR'S SIGNATURE Charles Judge	

04708

CERTIFICATE OF DEATH

Reg. Dist. No.

04707

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Daniel Middle --- Last Hardesty		4. DATE OF DEATH Month April Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1872
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR: Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Harwood, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Hardesty		14. MOTHER'S MAIDEN NAME Betty Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO ---	
17. INFORMANT Robert Lee Hardesty		Address Lothian, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - generalized, severe 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 19 66 , to 1 Apr 19 66 , that I last saw the deceased alive on 31 Mar 19 66 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 4/1/66 ACTUAL SIGNATURE Robert B. Sasscer M.D. Upper Marlboro, Maryland: PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D. Upper Marlboro, Maryland:			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/66	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Lothian, A.A. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Pub'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 13 1966 24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04709

CERTIFICATE OF DEATH

04708

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Prince Frederick	
3. NAME OF DECEASED (Type or print) First Sarah Middle L. Last HARDESTY		4. DATE OF DEATH Month April Day 7 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1870
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Howard		14. MOTHER'S MAIDEN NAME Sarah Evers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Everett Hall - Prince Frederick Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 11 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard I. Hochman attended the deceased from 3/26 , 1966, to 4/7 , 1966, that (I) (we) last saw the deceased alive on 4/1 , 1966, and that death occurred at 8:10 AM from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 4/7/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Barstow - Calvert Co., Md.	
24. FUNERAL DIRECTOR A. Q. Harkness & Son - Baltimore		25a. REG'D BY REGISTRAR APR 11 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04710

CERTIFICATE OF DEATH

04709

1. PLACE OF DEATH a. COUNTY <u>H.H. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>DEL.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER DARBY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>131 PORTER RD.</u>		d. STREET ADDRESS <u>302 MARGATE RD.</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA W. HARRISON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-1894</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>25</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WEILAND</u>		14. MOTHER'S MAIDEN NAME <u>UNIK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNIK</u>	
17. INFORMANT <u>MRS. JAMES BALZER #1</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, Liver</u> 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>4-20</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>66</u> to <u>4-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>66</u> , and that death occurred at <u>4-25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W.P. Stephens</u>		22b. DATE SIGNED <u>4-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm P. Stephens</u>		22d. ADDRESS <u>38 Cornhill Annapolis Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CUMBERLAND CEMT.</u>		23d. LOCATION (City, town or county) (State) <u>LIMA DEL. Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Stephens</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04711 CERTIFICATE OF DEATH 04710									
1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A. Co.</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>212 - W 11th Ave.</i>					d. STREET ADDRESS <i>212 W - 11th Ave.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Melvin J. Haynie</i>		4. DATE DEATH <i>April 29 1966</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Aug 23, 1912</i>		9. AGE (in years last birthday) <i>53</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Die Repair</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>W. Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Andrew J. Haynie</i>		14. MOTHER'S MAIDEN NAME <i>Jane Buckhannon</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Family</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatoid spondylitis</i>		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <i>11-8</i> , 1963, to <i>4-29</i> , 1966, that (I) (we) last saw the deceased alive on <i>April 29</i> , 1966, and that death occurred at <i>10:30</i> PM, from the causes and on the date stated above.		22a. SIGNATURE <i>Morton M. Krueger</i>		22b. DATE SIGNED <i>April 30, 1966</i>		22c. PHYSICIAN'S NAME (Type) <i>Morton M. Krueger</i>	
22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/3/66</i>		23c. NAME OF CEMETERY OR CREMATOR <i>St. Mary's</i>		23d. LOCATION (City, town or county) (State) <i>A.A. Co. Md.</i>	
24. FUNERAL DIRECTOR <i>McCurly F.H.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>MAY 4 1966</i>		25d. ADDRESS <i>237 Lafayette Ave.</i>	

FOR STATE
HEALTH DEPT.

04712

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7, 16 Film G376 4/26/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04711

1 PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if instit on Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AACO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOM - NORTH ARUNDEL Hosp</u>		e. STREET ADDRESS <u>119. Wilson Blvd S/W</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asphalt Service</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(unknown) Hill</u>	
14. MOTHER'S M A DEN NAME <u>(unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO <u>218-03-6394</u>		17. INFORMANT <u>Mr. Roy Hill (son)</u> Address <u>Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic gangrene</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <u>1500</u> (c) <u>arteriosclerotic gangrene</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1500</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1500</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u> M.D.		22. DATE SIGNED <u>4-7-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn R F D, Md.</u>
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25. REC'D BY REGISTRAR <u>APR 13 1966</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04713 CERTIFICATE OF DEATH 04712

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Bayside, Md</u> c. LENGTH OF STAY IN 1b <u>1417 Houghton Rd. Glen Burnie</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1417 Houghton Rd. Glen Burnie</u> d. STREET ADDRESS <u>Hospital Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>A.</u> Last <u>Hospital/HORN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George W. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Morsella, Pals Grove</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Clarence M. Knight</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>65</u> , to <u>4/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>66</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sidney R. Gehlert</u>		22b. DATE SIGNED <u>4/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sidney R. Gehlert, M.D.</u>		22d. ADDRESS <u>4700 Pennington Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4.18.66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300.4th st N E</u>		25a. REC'D BY REGISTRAR <u>APR 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04714					04713						
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Andrew E. Jaglas			4. DATE OF DEATH Month Day Year April 7, 1966								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1919		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR (If under 24 hrs.) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (County & State, or foreign country) New Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Jaglas					14. MOTHER'S MAIDEN NAME Mary Burchikas						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sarah R. Jaglas (wife)			Address Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4201 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 12 hours 1-2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4-5, 1966, to 4-7, 1966, that (I) (we) last saw the deceased alive on 4-7, 1966, and that death occurred at 5:10 AM, from the causes and on the date stated above.											
22a. SIGNATURE H.T.O. Herlihy M.D.										22b. DATE SIGNED 4-7-66	
22c. PHYSICIAN'S NAME (Type) H.T.O. HERLIHY M.D.										22d. ADDRESS 5 Central Ave Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland					
24. FUNERAL DIRECTOR Richard V. Singleton				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04714

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural		c LENGTH OF STAY in 1b GILN BURNIE		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore-rural			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital				d STREET ADDRESS Bellgrove Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DIANE				4 DATE OF DEATH April 19 19 66			
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-6-57	9 AGE (In years last birthday) 8 yrs	FUNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Child		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore Md		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Samuel Norris				14 MOTHER'S MAIDEN NAME Catherine Norris			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Samuel Norris, 5901 Bellegrove Rd			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing injuries of head and trunk 130 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Bicycle-truck collision					
20c TIME OF INJURY Month, Day, Year 4:50 p.m. 4/19 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) street		20f (City or town) (County) (State) Anne Arundel	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker		M.D. Rudiger Breiteneker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/20/66	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4-23-66		23c NAME OF CEMETERY OR CREMATORY Mt Calvary		23d LOCATION (City or town) (County) (State) Brooklyn AA Co. Md	
24 FUNERAL DIRECTOR Burnell B. Oden - Baltimore Md				25a REC'D BY REGISTRAR APR 27 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~It~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04716 CERTIFICATE OF DEATH 04715

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - GLEN BURNIE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NORTH ARUNDEL GENERAL HOSP.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE d. STREET ADDRESS 1609 MANNING RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) LOTTIE ANN JOHNSON		4. DATE OF DEATH Month APRIL Day 26 Year 1966		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 23, 1890		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY Medical				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Driver						14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-30-9679				17. INFORMANT Rollins R. Johnson - 211 Fifth Ave Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive heart failure DUE TO (b) myocardial infarct DUE TO (c) coronary atherosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH hours weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 66 , to 4/26 , 19 66 , that (I) (we) last saw the deceased alive on 4/25 , 19 66 , and that death occurred at 7:45 M, from the causes and on the date stated above.															
22a. SIGNATURE Ernest Leopold										ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/29/66				23c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.				23d. LOCATION (City, town or county) (State) Balto Md.			
24. FUNERAL DIRECTOR Walters Funeral Home - Balto. Md.										25a. REC'D BY REGISTRAR MAY 2 1966				25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04717 Item 7 Film 3576 2/4/66 mh 04716											
1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Charles</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Charles</u>				c. LENGTH OF STAY IN 1b <u>St. Charles</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Plaza Manor Nursing Home, 90 Wisconsin Ave., St. Charles</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1876</u>		9. AGE (In years last birthday) <u>90</u> ya.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-3880</u>		17. INFORMANT Name <u>Louise Shorter</u> Address <u>Crownsville, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 day</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>3/3/66</u> , 19 <u> </u> to <u>4/25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4/25/66</u> .. 19 <u> </u> .. and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Hunt</u>											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>											
22d. ADDRESS <u>100 Cherry Lane, Glen Burnie, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>4-30-66</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Watersbury, Md</u>											
23d. LOCATION (City, town or county) (State) <u>Watersbury, Md</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. F. E. S. # 05 N Washington</u>											
25. REC'D BY REGISTRAR <u>MAY 2 1966</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>											



04718

CERTIFICATE OF DEATH

04717

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY (in days) Annopolis		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 517 Ridgely Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maude Gertrude JONES		4. DATE OF DEATH Month April Day 11 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1888
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State or foreign country) Wash DC - Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY T. MILLER		14. MOTHER'S MAIDEN NAME MATTIE BOUSCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS HELEN ROSS LINDAMOR of SEVERN		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Unknown	
19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 3/30, 1966 to 4/11, 1966 , that (I) (we) last saw the deceased alive on 4/10, 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 7:30 AM 4/11/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-14-1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR-SONS		25a. REC'D BY REGISTRAR APR 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04719

CERTIFICATE OF DEATH

04718

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3 mos. 29 das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1915 Regester Street	
3 NAME OF DECEASED (Type or print) #31115 James E Jordan		4. DATE OF DEATH Month 4 Day 29 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/05
9. AGE (n years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Man		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Jordan		14. MOTHER'S MAIDEN NAME Lucy E. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212 05 0871	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Dehydration and Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15/1966, to 4/29/1966, that (I) (we) last saw the deceased alive on 4/29/1966, and that death occurred at 9:15M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 4/29/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/66	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc.		25a. REC'D BY REGISTRAR MAY 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>4 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Annapolis Nursing & Convalescent</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>408 3rd St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>John S. Kane</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1966</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>CAUCAS</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/6/1898</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RET. CIVIL SERVICE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>FARMINGTON, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward Kane</u> 14. MOTHER'S MAIDEN NAME <u>Elle M C Revel</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>RHODA F. KANE</u> Address <u>#2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary's disease</u> 300X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 gm.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>4/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>66</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard N. Peeler</u>						22b. DATE SIGNED <u>4/16/66</u>		22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>			23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>			
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04721

04720

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. GEORGE G. MEADE			c LENGTH OF STAY IN 1b 2 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL			d. STREET ADDRESS 842 WEST 37TH STREET		
3 NAME OF DECEASED (Type or print) ELLEN ANN KEMP			4 DATE OF DEATH APRIL 29 1966		
5 SEX FEMALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 JANUARY 1902		9. AGE (In years, last, b.r.h.day) yrs. 64
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State or foreign country) MONTGOMERY, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME HENRY (?) KING			14. MOTHER'S MAIDEN NAME DAYMIDE Cora E. Daymide		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 217-12-0622	17 INFORMANT MR LAWRENCE KEMP 842 WEST 37TH STREET BALTIMORE, MARYLAND		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN					INTERVAL BETWEEN DEATH AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from 28 APRIL 1966 , to 29 APRIL 1966 , that (1) (we) saw the deceased alive on 29 APRIL 1966 , and that death occurred at 7:30 PM , from causes and on the date stated above					
22a. SIGNATURE <i>Roald A. Nelson</i>			22b. DATE SIGNED 30 APRIL 1966		
22c. PHYSICIAN'S NAME (Type) ROALD A NELSON, MAJOR, MC			22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FGGM, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 3, 1966	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Balto. Md.		
24 FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.			25a. REC'D BY REGISTRAR MAY 4 1966		
			25b. REGISTRAR'S SIGNATURE <i>J. C. Judge</i>		

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

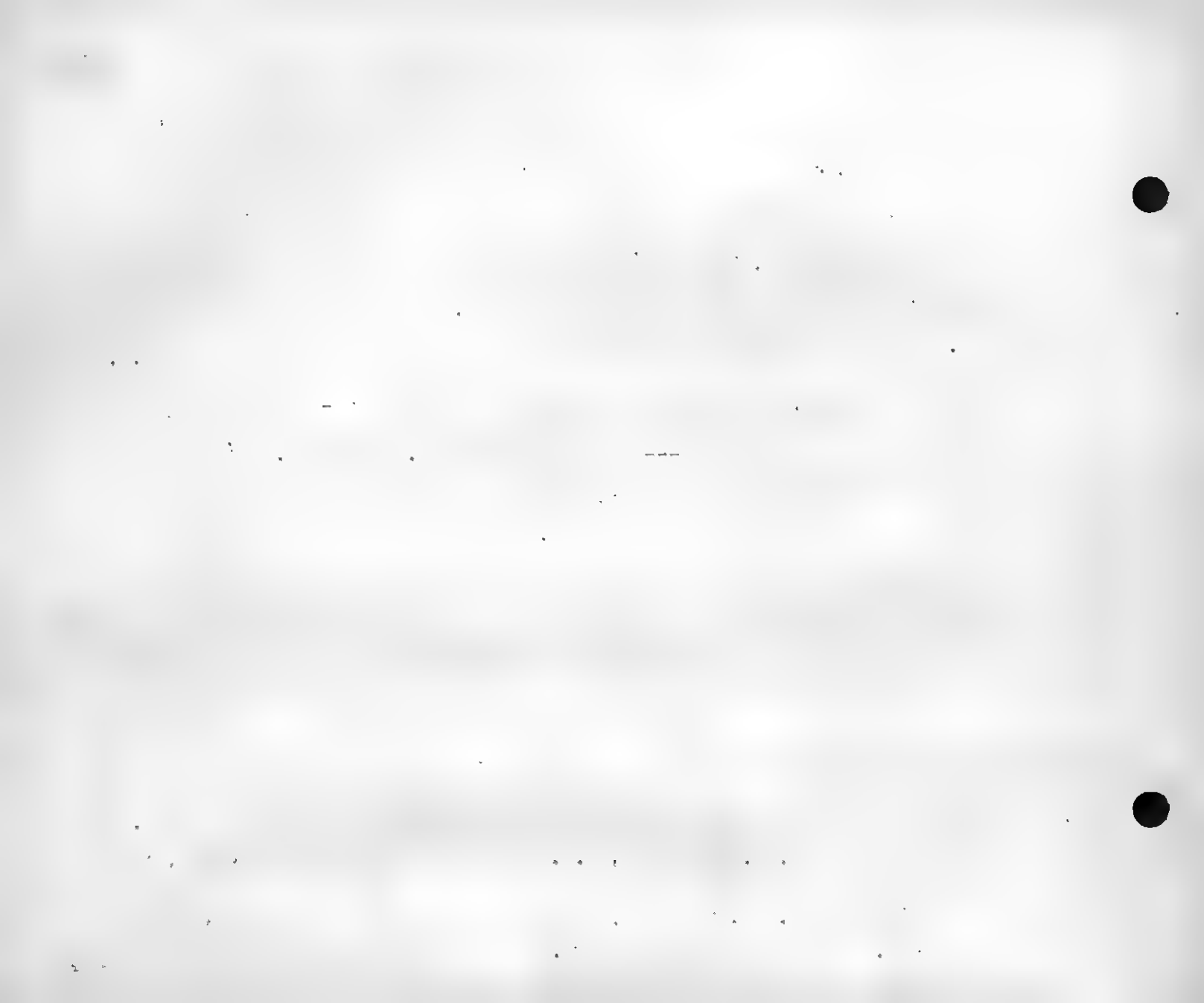
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01722

04721

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN ID 33 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 Hammonds Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7 Hammonds Lane 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA J. KENNY (Konieczny)		4. DATE OF DEATH Month April Day 22 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1900
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Simon Drzymala		14. MOTHER'S MAIDEN NAME Mary Anna ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Stephen J. Kenny, Sr. (same)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma - Cerebrum 151A DUE TO Carcinoma of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr , 19 56 , to 22 Apr , 19 66 , that (I) (we) last saw the deceased alive on 21 Apr 19 66 , and that death occurred at 2 P M, from the causes and on the date stated above.			
22a. SIGNATURE Andrew R. Sosnowski		22b. DATE SIGNED Apr. 23, 1966	
22c. PHYSICIAN'S NAME (Type) A. R. Sosnowski, M.D.		22d. ADDRESS 4016 Ritchie Highway, Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 26, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy.		25a. REC'D BY REGISTRAR APR 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04723
04722

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY in 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>34 Brookfield Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>34 Brookfield Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JASPER</u> Middle <u>JACK</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4th 1903</u>	
9. AGE (In years last birthday) <u>62</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Potomac Electric Power Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Knight</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Mae Gatos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-3663</u>	
17. INFORMANT <u>Mrs. Helen Knight</u>		Address <u>Same as # 2. (Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>446X</u> DUE TO Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC HEPATIC-RENAL FAILURE</u> DUE TO (c) <u>NEPHROSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u> <u>1 YEAR</u> <u>1 YEAR</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>1 YEAR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>July</u> <u>1965</u> to <u>April</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>4-5-1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Lankford Jr., M.D.</u>		22b. DATE SIGNED <u>4-7-66</u>	
22c. PHYSICIAN'S NAME (Print) <u>ARTHUR LANKFORD, JR., M. D.</u>		22d. ADDRESS <u>2934 Mountain Rd Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 11th 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sims Bros.</u>		25. ADDRESS <u>1661 Good Hope Rd., SE Wash DC</u>	
25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04724

04723

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

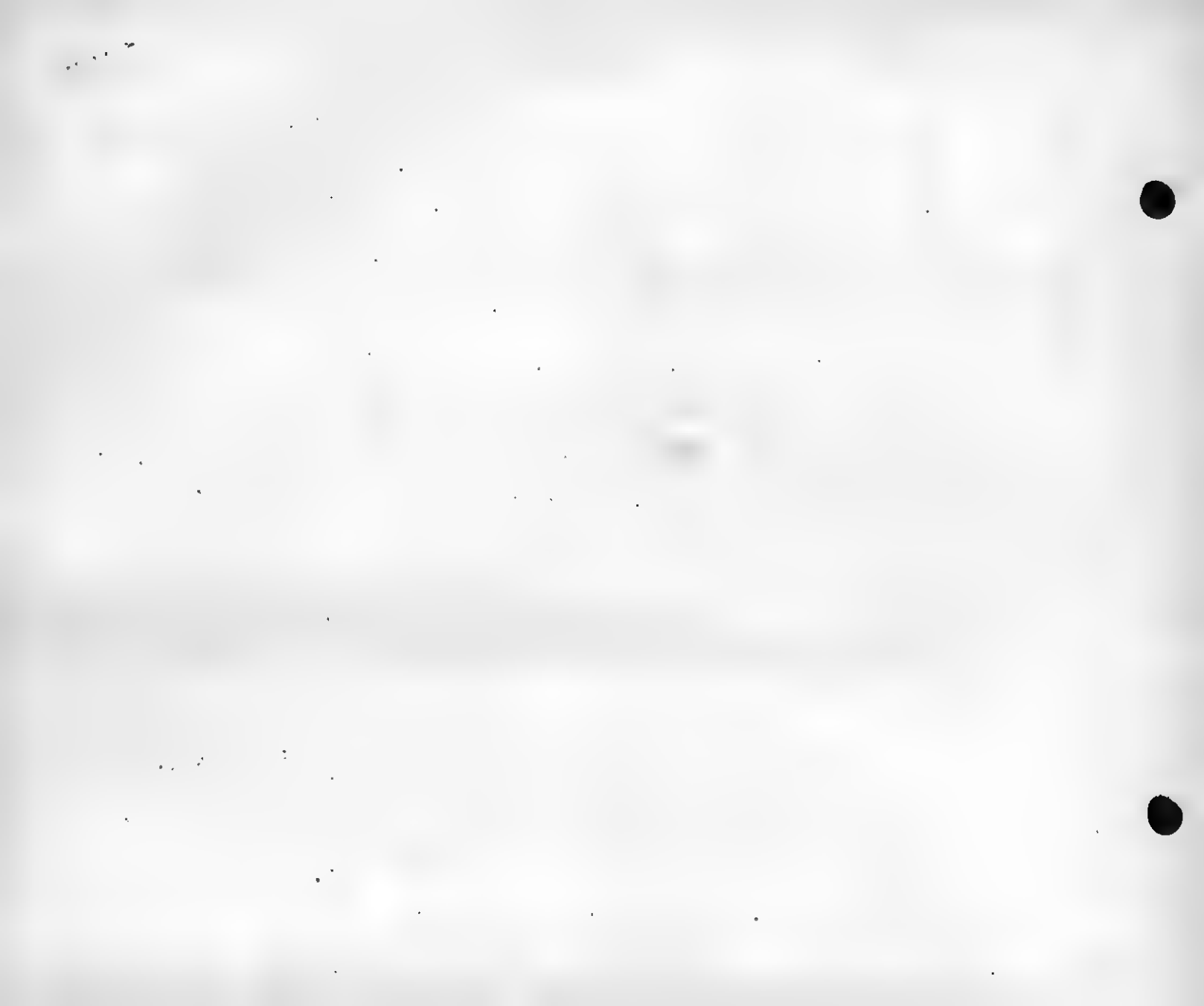
1. PLACE OF DEATH a. COUNTY <u>ALCO</u>		2. USUAL RESIDENCE (Where deceased lived, if not in hospital on admission) a. STATE <u>MD</u> b. COUNTY <u>ALCO</u>	
b. CITY OR TOWN (If outside corporate limits, write R.R.A. and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN Ia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O.A. - Northwood - Hosp</u>		d. STREET ADDRESS <u>1510</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>J</u> Last <u>Kobe Sr</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1905</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John Kobe</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Armstrong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Family</u>		Address <u>Baltimore</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> MD		22. DATE SIGNED <u>Apr 17/66</u>	
EXAMINER'S NAME (Type) <u>C. L. [Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>4-21-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Greenwood Md</u>	
24. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 22 1966</u>	
ADDRESS <u>237 Patuxent Ave</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04725
04724
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY A. ARUNDEL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY A. ARUNDEL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hosp.		d. STREET ADDRESS Oakwood Rd. Glen Burnie	
3. NAME OF DECEASED (Type or print) First RICHARD Middle R. Last LABRECQUE		4. DATE OF DEATH Month APRIL Day 18 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1924
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	
11. BIRTHPLACE (County & State, or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Labregue		14. MOTHER'S MAIDEN NAME Gertrude Ladue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W.W.II		16. SOCIAL SECURITY NO. 046-14-1027	
17. INFORMANT Mrs. Hazel I. Labregue (wife)		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1965 , to Sept. 15, 1965 , that (I) (we) last saw the deceased alive on Sept 15 1965 , and that death occurred at 9:30 AM , from the causes and on the date stated above.		22b. DATE SIGNED 4/18/66	
22a. SIGNATURE Edmond P. Touchette		22c. PHYSICIAN'S NAME (Type) Edmond P. Touchette	
22d. ADDRESS Pitchie Hwy, Glen Burnie Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 22, 1966	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Balto, Md.	
24a. FUNERAL DIRECTOR R.V. Singleton		24b. ADDRESS Singleton Funeral Home, Glen Burnie, Md.	
25a. REC'D BY REGISTRAR APR 21 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

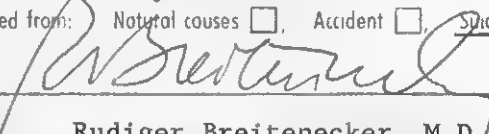

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04726

04725

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Earleigh Heights Rd. and Richie Highway				e. STREET ADDRESS Half-Way House Earleigh Heights Rd. and Richie Highway			
3 NAME OF DECEASED (Type or print) First STERLING Middle Norris Last LEACH				4 DATE OF DEATH Month April Day 19 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1920	
9. AGE (In years last birthday) 45 yrs		IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (State or foreign country) Fauquier Co., Va.				12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME E. P. Leach				14. MOTHER'S MAIDEN NAME Bessie Furr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II				16 SOCIAL SECURITY NO 223-40-2272		17 INFORMANT Mr. Luther E. Payne Warrenton, Va.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple incised wounds of neck and arms DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Cut throat and arms			
20c. TIME OF INJURY Month, Day, Year Hour 8:55 p.m. 4/19 19 66				20d. INJURY OCCURRED Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not where <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) tavern	
20f. (City or town) Anne Arundel				20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED 4/20/66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/20/1966		23c. NAME OF CEMETERY OR CREMATORY Warrenton Cemetery		23d. LOCATION (City or Town) (County) (State) Warrenton, Va.	
24. FUNERAL DIRECTOR Wm. J. Schenck-Loss				25a. REC'D BY REGISTRAR APR 25 1966		25b. REGISTRAR'S SIGNATURE 	

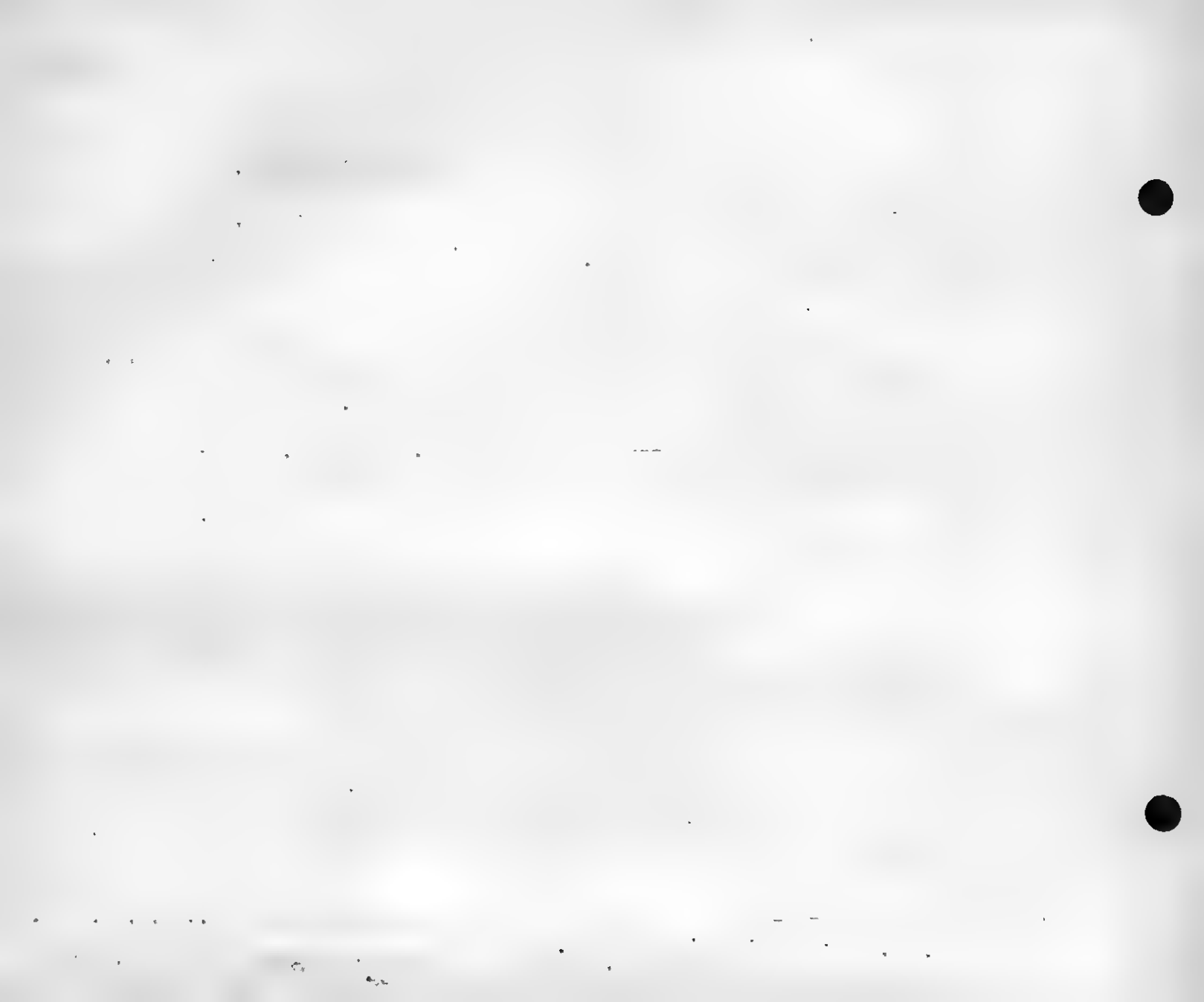


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04727 CERTIFICATE OF DEATH 04726

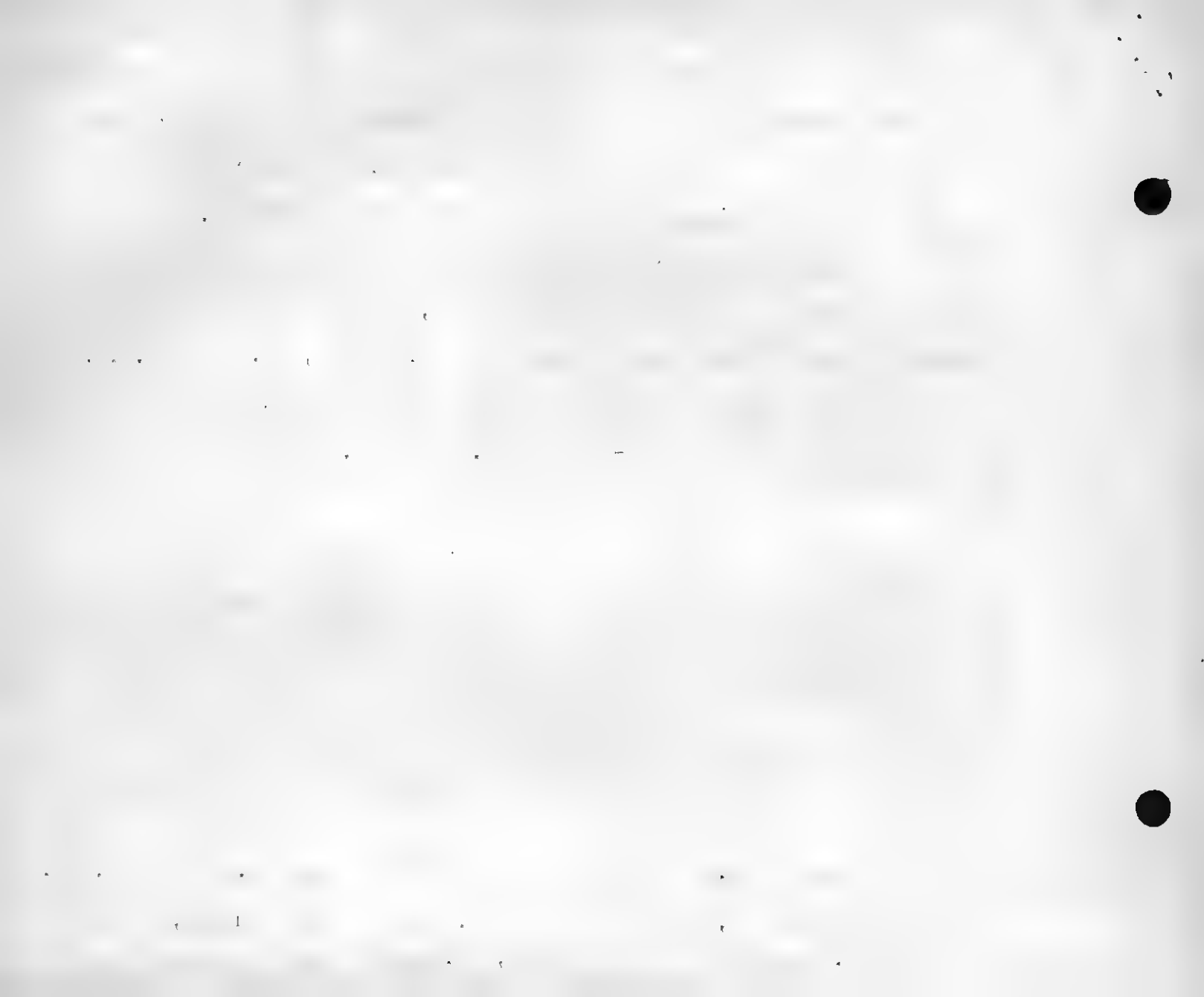
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H. H.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>206 Southbridge Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>F.</u> Middle <u>Ledley</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Maryland</u>	
13. FATHER'S NAME <u>Charles Ledley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Charles F. Ledley, Jr. (same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UNDETERMINED INTERSTITIAL</u> <u>525X</u> DUE TO <u>PNEUMONITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-4</u> , 19 <u>66</u> to <u>4-22</u> , 19 <u>66</u> that (II) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>66</u> and that death occurred at <u>2:30</u> A.M. <u>4/22/66</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Shelmo Bob</u>		22b. DATE SIGNED <u>4/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Shelmo Bob</u>		22d. ADDRESS <u>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-23-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy., A.A.Co., Md.</u>
24. FUNERAL DIRECTOR <u>George J. Gonc</u>		25a. REC'D BY REGISTRAR <u>APR 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04728 CERTIFICATE OF DEATH 04727											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie (Ferndale)					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS #208 Hollins Ferry Rd.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital											
3. NAME OF DECEASED (Type or print) First William Middle (nmi) Last Lehnert						4. DATE OF DEATH Month April Day 8 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1894		9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer(Ret) House Correction						10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.			11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME Clements Lehnert					
14. MOTHER'S MAIDEN NAME Marie Lindeman						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None					
16. SOCIAL SECURITY NO. 212-03-2477						17. INFORMANT Address Mrs. Myrtle E. Lehnert (wife) Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA & URINARY TRACT INFECTION 2 days -- 3 wks											
DUE TO (b) ACUTE & CHRONIC ADRENAL INSUFFICIENCY - 2 yrs											
DUE TO (c) CHRONIC PULMONARY TUBERCULOSIS INACTIVE 15 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 19 66 to present , 19 66 , that (I) (we) last saw the deceased alive on 4/7 19 66 , and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Leymond W. Lott M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED 4/8/66											
22c. PHYSICIAN'S (Type) Leymond W. Lott M D											
22d. ADDRESS 529 Camp Meade Rd. Linthicum, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF April 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland			
24. FUNERAL DIRECTOR Richard V. Singleton						ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR APR 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04729 CERTIFICATE OF DEATH 04728											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY CROWNSVILLE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN ID 1 WEEK				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CROWNSVILLE STATE HOSPITAL				d. STREET ADDRESS 402 MARY AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN FREDERICK LEPHARDT				4. DATE OF DEATH Month APRIL Day 30 Year 1966				5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3-20-1883 9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER				10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY				11. BIRTHPLACE (County & State, or foreign country) MD.			
13. FATHER'S NAME CHRISTOPHER LEPHARDT				12. CITIZEN OF WHAT COUNTRY? U.S.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 215-03-1298				17. INFORMANT RECORDS: CROWNSVILLE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 WEEK YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 4/23/66 , 19 to 4/30/66 , 19, that (I) (we) last saw the deceased alive on 4/30/66 , 19, and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE L. BENEDICT				22b. DATE SIGNED 4/30/66				22c. PHYSICIAN'S NAME (Type) L. BENEDICT			
22d. ADDRESS CROWNSVILLE STATE HOSPITAL				23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 5-3-66 23c. NAME OF CEMETERY OR CREMATORY Green Mount 23d. LOCATION (City, town or county) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR WILBICH FUNERAL HOME 4200 BELAIR RD				25a. REC'D BY REGISTRAR MAY 9 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

04730

CERTIFICATE OF DEATH

04729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annopolis		2. USUAL RESIDENCE (Where deceased lived, if inst tuton: Residence before adm'ssion) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 15 Monticello Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Irene Elizabeth MARTIN		4. DATE OF DEATH Month Day Year April 17 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1892
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN W. ARMIGER		14. MOTHER'S MAIDEN NAME LAURA M. KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOSEPH F. MARTIN SR. #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) Cerebral Vascular Disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 5 WKS 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from Mar. 17 , 19 66 , to Apr. 17 , 19 66 that (I) yes last saw the deceased alive on Apr. 17 , 19 66 , and that death occurred at — M, from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck 22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22b. DATE SIGNED 3:40 AM MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 71 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-19-66	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.
24. FUNERAL DIRECTOR John M. Lytle & Sons Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Justice	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04731

04730

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 100 Eugenia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Norman Middle S. Last McGee		4. DATE OF DEATH Month April Day 29 Year 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Jan. 1902		9. AGE (In years last birthday) 64 yrs.		10. FUNDER 1 YEAR Months 02 Days 1		11. FUNDER 24 HRS. Hours 02 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME (unknown) McGee								14. MOTHER'S MAIDEN NAME Alice Tudar											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Reserve				16. SOCIAL SECURITY NO. 212-05-4332				17. INFORMANT Address Mrs. Frances E. McGee - Same as # 2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, recurrent 4x01 DUE TO (b) Intermittent cardiac arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —																INTERVAL BETWEEN ONSET AND DEATH 3 m - 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 65 , to 7/28 , 19 66 , that (I) was last saw the deceased alive on 4/28 , 19 66 , and that death occurred at 4:30 AM , from the causes and on the date stated above.																			
22a. SIGNATURE W. W. Peckham				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4/29/66				22c. PHYSICIAN'S NAME (Type) R. W. Peckham, M.D.				22d. ADDRESS Glen Burnie, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2 May 1966				23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.				23d. LOCATION (city, town or county) (State) Glen Burnie, Maryland							
24. FUNERAL DIRECTOR Robert Peckham				ADDRESS Singleton Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR MAY 3 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							



04732

CERTIFICATE OF DEATH

04731

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Gambrells	
3. NAME OF DECEASED (Type or print) First Charles Middle Wilbur Last McKNEW		4. DATE OF DEATH Month April Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1884
9. AGE (n years last birthday) yrs 81		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building Const.	
11. BIRTHPLACE (County & State, or foreign country) Woodbine, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George McKnew		14. MOTHER'S MAIDEN NAME Mary Boetler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-07-8299	
17. INFORMANT Mrs. Madelyn Downs - Gambrells, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 MIN 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ANEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the doctor attended the deceased from April 6, 1966 , to April 6, 1966 , that (I) we saw the deceased alive on April 6, 1966 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE H. Logan Holtgrewe, M.D.		22b. DATE SIGNED 4/6/66	
22c. PHYSICIAN'S NAME (Type) H. Logan Holtgrewe, M.D.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Beverly E. Hopping		25a. REC'D BY REGISTRAR Charles Judge	
HOPPING FUNERAL HOME - Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

04732

1 PLACE OF DEATH a COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD.</u> b COUNTY <u>A.A. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Andrew</u> Middle <u>McLaughlin</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-6-1965</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) yrs <u>9</u>
11 BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANCIS C. McLAUGHLIN</u>		14. MOTHER'S MARDEN NAME <u>MARY T. LIBBEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>FRANCIS C. McLAUGHLIN #2</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 5 & 1 d. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>respiratory infection</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---

20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from Birth, 19—, to March 12, 1966, that (I) (we) last saw the deceased alive on March 12, 1966, and that death occurred at — M, from causes and on the date stated above.

22a. SIGNATURE <u>Frank M. Kopark</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-1-66</u>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <u>ANNAPOLIS, MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-2-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
--	------------------------------------	---	---

24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>	25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-1-100 X

Arrogance M.D.

Francis C. Mc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04734

CERTIFICATE OF DEATH

04733

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fennel - Chesapeake</u> c. LENGTH OF STAY IN TB <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St 2 - 2nd Ave. Garland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fennel</u> d. STREET ADDRESS <u>2 N. Second Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elsie Irene Meldrom</u> First Middle Last 4. DATE OF DEATH <u>April 20 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 25 1897</u> Month Day Year 9. AGE (In years last birthday) <u>68</u> yrs. 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>25</u> 11. IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County, state, or foreign country) <u>Baltimore Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Hunter Ayl</u> 14. MOTHER'S MAIDEN NAME <u>Blanche S. Strong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Lawrence I. Meldrom</u> Address <u>2 N. 2nd. Ave.,</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>443X</u> DUE TO (b) <u>Hypertension & Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> <u>10-15 yrs</u> <u>5 yrs</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>4/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>66</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Chas. L. Ball, Jr.</u> M.D. 22b. DATE SIGNED <u>4/20/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr.</u> 22d. ADDRESS <u>Emthorion 3rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-23-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		25a. REGISTRY REGISTRAR <u>APR 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



04735

CERTIFICATE OF DEATH

04734

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 5 mos. 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 283 Ballou Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#26237 Elizabeth Michel		4. DATE OF DEATH Month 4 Day 10 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1894
9. AGE (In years last birthday) yrs 71		10. IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Michel		14. MOTHER'S MAIDEN NAME Henrietta Weber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO 219-22-7279	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/16 , 19 65 , to 4/10 , 19 66 , that (I) (we) last saw the deceased alive on 4/10 , 19 66 , and that death occurred at 3A. M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 4/11/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/13/66	23c. NAME OF CEMETERY OR CREMATORY Univ. of Maryland	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR William Reese II		25a. REC'D BY REGISTRAR APR 14 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

04736

04735

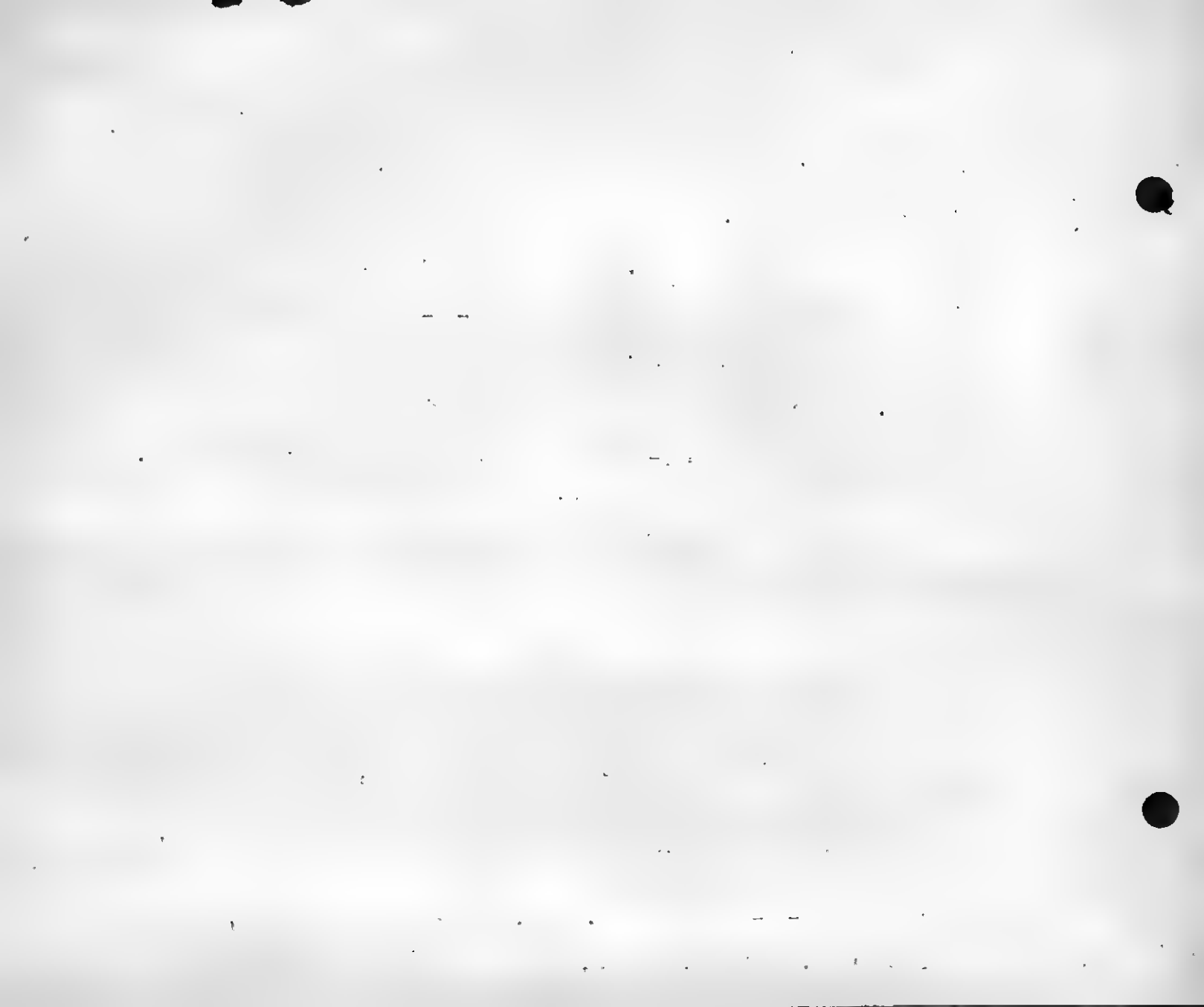
1. NAME OF DECEASED (Type or Print) JOSEPH JOHN MILCHENSKI		2. DATE AND HOUR OF DEATH April 19, 1966		3 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ANNE ARUNDEL COUNTY FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE - 25 4217 Third St. Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY AN. D. ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 25 D. STREET ADDRESS (If rural, give location) 4217 Third St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Nov. 21, 1907	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Union Bag Box Factory		11. BIRTHPLACE (State or foreign country) Polland	
13. FATHER'S NAME Thomas Milchenski		14. MOTHER'S MAIDEN NAME Sophie Rosiak		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 195-09-8107		17. INFORMANT Elizabeth Milchenski (same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe Pulmonary Obstructive Airway Disease		19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Myocardial Ischemia		INTERVAL BETWEEN ONSET AND DEATH 1964-1966	
ANTECEDENT CAUSES DISEASES & CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 19 68 to April 19 66 that (I) (we) last saw the deceased alive on 5 April 19 66 and that in (my) (our) opinion death occurred on the dot and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Mario J. Reda M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED April 20, 1966	
23C. PHYSICIAN'S NAME (Type) Mario Reda		23D. ADDRESS M.D. 4016 Ritchie Hwy., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 23, 66		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park	
				24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A.Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1966		25B. NAME OF REGISTRAR Charles Judge		25C. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																												
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>North Arundel Gen Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Box 176 Route 6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																						
3. NAME OF DECEASED (Type or print) <u>John T. Miller</u>			4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10-28-20</u>			9. AGE (In years last birthday) <u>45</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																										
Months	Days	Hours	Min.																									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coast Guard Yard</u>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
13. FATHER'S NAME <u>John C. Miller</u>						14. MOTHER'S MAIDEN NAME <u>Marie Hess</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>			16. SOCIAL SECURITY NO. <u>213-18-1922</u>			17. INFORMANT <u>Elizabeth Miller, Same as line D.</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerotic heart disease</u> CAUSE TO												INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) this physician attended the deceased from <u>August 27, 1965</u> to <u>present</u>, 19 <u> </u>, that (I) (we) last saw the deceased alive on <u>January 17, 1966</u>, and that death occurred at <u>9:10 PM</u> from the causes and on the date stated above.																												
22a. SIGNATURE <u>C. Earl Hill</u>															22b. DATE SIGNED													
22c. PHYSICIAN'S NAME (Type) <u>C. Earl Hill, M.D.</u>						22d. ADDRESS <u>395 Ft. Smallwood Rd. Pasadena Maryland 21122.</u>																						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>4-18-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Natl. Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>																
24. FUNERAL DIRECTOR <u>McCullys, 130 E. Fort Ave, Balto, Md</u>						25a. REC'D BY REGISTRAR <u>APR 18 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																



04738

CERTIFICATE OF DEATH

04738

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 39yrs. 3mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) #04724 Jeanette Neal		4. DATE OF DEATH Month 4 Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - - 1895 ?
9. AGE (In years last birthday) 69 ? yrs		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Unknown
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Hospital Records Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/9/19 36, to 4/5/19 66, that (I) (we) last saw the deceased alive on 4/5/19 66, and that death occurred at 2:30 M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 4/7/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-7-66	23c. NAME OF CEMETERY OR CREMATORY W. Baltimore	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.
24. FUNERAL DIRECTOR William Reese, #108 W. Washington St. City		25a. REC'D BY REGISTRAR DATE APR 11 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

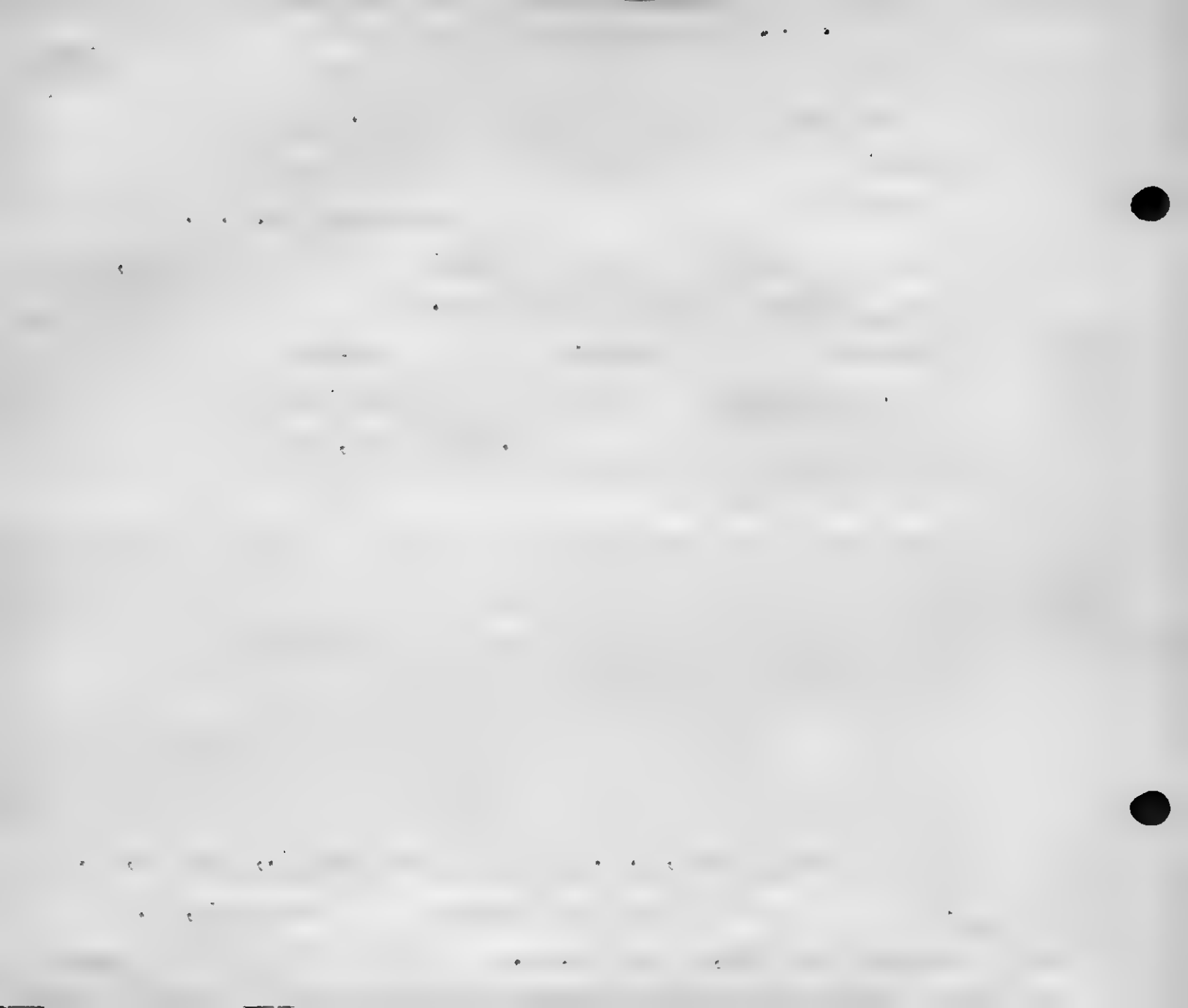
CERTIFICATE OF DEATH

04739

04739

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 604 Stewart Ave. S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary 4. DATE OF DEATH April 13, 1966	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10 Mar. 1885	9. AGE (In years last birthday) 81 yrs.	10. BIRTHPLACE (County & State, or foreign country) Ireland	11. CITIZEN OF WHAT COUNTRY? USA
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	13. FATHER'S NAME John Mulcahy	14. MOTHER'S MAIDEN NAME Margaret Doyle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. Mr. Thomas Nevin, same as 2	17. INFORMANT Mr. Thomas Nevin, same as 2	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 151X DUE TO Cerebral of cerebral infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/12/66 , 19... to 4/13/66 , 19..., that (I) (we) last saw the deceased alive on 4/12/66 , 19..., and that death occurred at 3:30 P.M. , from the causes and on the date stated above.	
22a. SIGNATURE Gerard Church		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Gerard Church, M. D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 April 66	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kirkley Funeral Home, Glen Burnie, Md.		25. REC'D BY REGISTRAR APR 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

04740

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Davidsonville, Maryland	
3 NAME OF DECEASED (Type or print) First Middle Last Katherine Lou OAKLEY		4 DATE OF DEATH Month Day Year April 29 1966	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 59 yrs
10a. USUAL OCCUPATION (Give kind of work done during month preceding death) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James B. Kearns		14. MOTHER'S MAIDEN NAME Lou B. Trammell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Arthur W. Oakley same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 421 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) disease DUE TO (c) 12 years			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital), attended the deceased from March , 19 64 , to April 29 , 19 66 , that (I) (we) last saw the deceased alive on April 29 , 19 66 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Sylvia M. Lim		22b. DATE SIGNED 4/30/66	
22c. PHYSICIAN'S NAME (Type) Sylvia Lim, M.D.		22d. ADDRESS Rt. 1 Box 244, Mayo Rd, Edgewater, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 3, 1963	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR H. Gasch's Sons		25a. REC'D BY REGISTRAR MAY 2 1966	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04741

CERTIFICATE OF DEATH

04741

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort George G Meade		c. LENGTH OF STAY IN 1b 5/12	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
3. NAME OF DECEASED (Type or print) First EDWARD Middle JOSEPH Last O HARA		4. DATE OF DEATH Month APRIL Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14 1887
9. AGE (In years last birthday) yrs 79		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (County & State or foreign country) Hazleton, Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter O'Hara		14. MOTHER'S MAIDEN NAME Mary (Maiden Name Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1&2		16. SOCIAL SECURITY NO 262-78-7198	
17. INFORMANT W.J. O'Hara (Son)		Address Same As Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5/12
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from 23 Nov , 19 66 , to 13 Apr , 19 66 that (X) (we) last saw the deceased alive on 13 Apr , 19 66 , and that death occurred at 2:40 PM , from causes and on the date stated above.			
22a. SIGNATURE L. W. Holder		22b. DATE SIGNED 13 Apr 66	
22c. PHYSICIAN'S NAME (Type) L. W. HOLDER, CAPT, MC		22d. ADDRESS HQ Kimbrough Army Hospital FT Meade, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/16/66	
23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields Cath Cem		23d. LOCATION (City or Town) (County) (State) Millersville, Md.	
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR APR 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04742

04742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne A. undel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riva		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 524 Riva Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle OSTER Last OSTER				4. DATE OF DEATH Month April Day 11 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1892		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 14 Days 10 Hours 4 Min.	11. IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work ng. life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Cincinnati Ohio		12. CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Oster				14. MOTHER'S MAIDEN NAME Emma Rodenhouse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 288-10-4914		17. INFORMANT Mrs. Anna A. Oster - same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) 14 HOURS 10 YRS.						INTERVAL BETWEEN ONSET AND DEATH 14 HOURS 10 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC CHOLECYSTITIS & CHOLELITHIASIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from APRIL 4, 1958 , to Apr. 11, 1966 , that (I) (we) saw the deceased alive on Apr. 11, 1966 , and that death occurred at 10:10 PM , from causes on and on the date stated above.							
22a. SIGNATURE Edward S. Beck				22b. DATE SIGNED 4-12-66		22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.	
22d. ADDRESS 71 Franklin St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF ?		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City or Town) (County) (State) Port Thomas, Campbell, Ky.	
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME				25. REC'D BY REGISTRAR APR 14 1966		26. REGISTRAR'S SIGNATURE Charles Judge	

04743

CERTIFICATE OF DEATH

04743

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 86 Pleasant St.,	
3. NAME OF DECEASED (Type or print) First Randolph Middle NMN Last PARKER		4. DATE OF DEATH Month April Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1913
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) A.A. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest Parker		14. MOTHER'S MAIDEN NAME Kate Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 214-05-2365	
17. INFORMANT Mrs Kate Alspp		Address 1962 West St Annapolis Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 321X DUE TO Cerebral hemorrhage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension. (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 4/12 , 19 66 , to Apr. 13 , 19 66 that (I) (we) last saw the deceased alive on Apr. 13 , 19 66 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE General Church		22b. DATE SIGNED 4/13/66	
22c. PHYSICIAN'S NAME (Type) General Church		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-16-1966	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md
24. FUNERAL DIRECTOR C.E. Hicks, 111		25a. REC'D BY REGISTRAR APR 15 1966	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

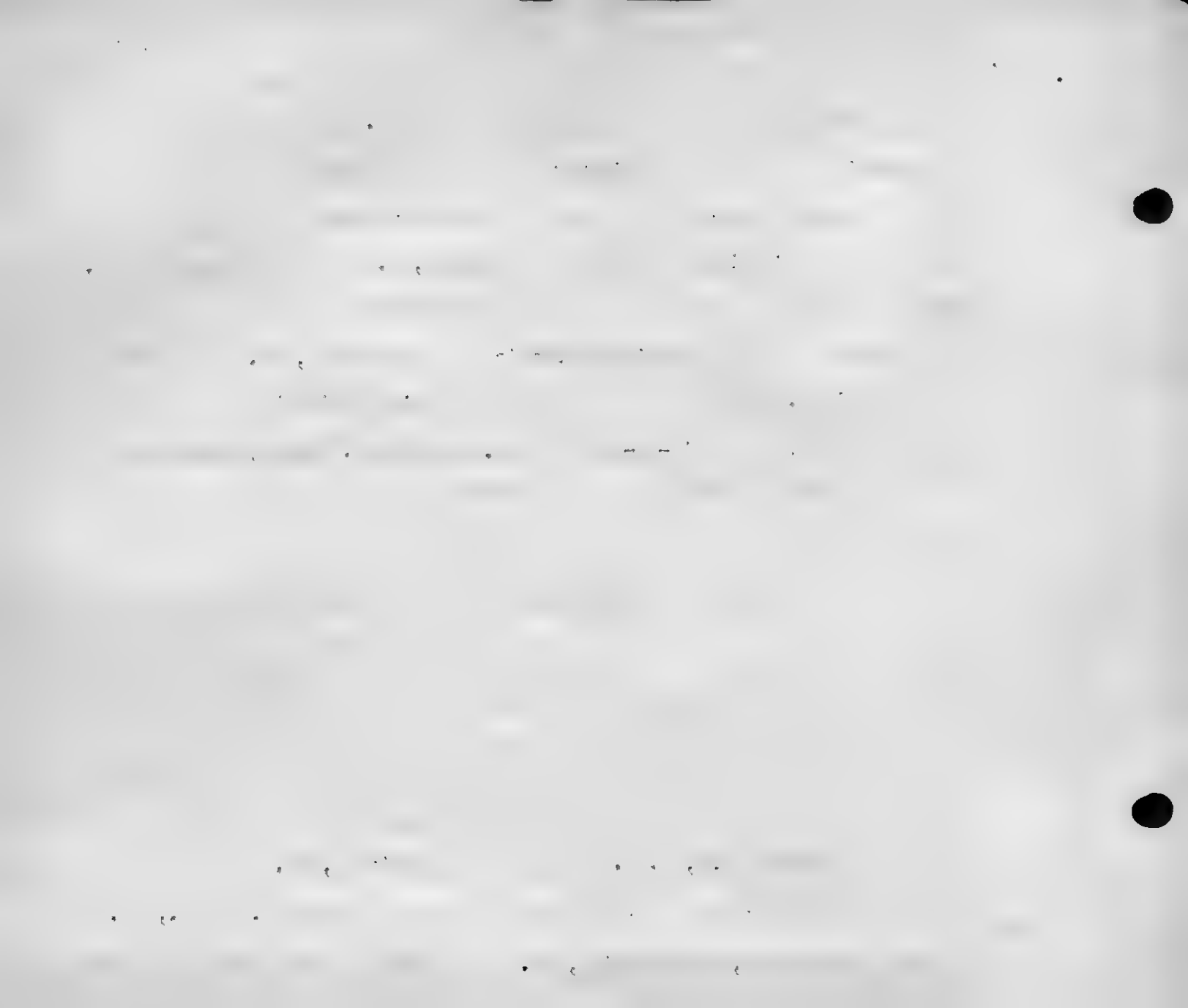
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04744

04744

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b Minutes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				e. STREET ADDRESS New Cut Road			
3. NAME OF DECEASED (Type or print) William Byron Phelps, Sr.				4. DATE OF DEATH April 15, 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 June 1908	
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie E. Phelps				14. MOTHER'S MAIDEN NAME Daisy Fairall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11 717-07-6852			
17. INFORMANT Mrs. Isabelle C. Phelps, same as 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardio-Vascular Disease DUE TO (b) Hypertension DUE TO (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 4/15 , 1966, that (I) (we) last saw the deceased alive on 4/15 , 1966, and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles L. Ball Sr.				22b. DATE SIGNED 4/16/66		22c. PHYSICIAN'S NAME (Type) Charles Ball, M. D.	
22d. ADDRESS Linthicum, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 18 April 66		23c. NAME OF CEMETERY OR CREMATORY Nichols Bethel Cemetery		23d. LOCATION (City, town or county) (State) Odenton, AA Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kirkley Funeral Home, Glen Burnie, Md.				25. REC'D BY REGISTRAR APR 18 1966			
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04745

CERTIFICATE OF DEATH

04745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. GEO. G. MEADE c. LENGTH OF STAY IN 1b 5 days		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 14 SHARON COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) SUSAN First MARIE Middle PITOCHELLI Last SEX FEMALE COLOR OR RACE CAU MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH APRIL 12 19 66 9 AGE (In years last birthday) 0 yrs. IF UNDER 1 YEAR Months 0 Days 5 IF UNDER 24 HRS Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SABATINO PITOCHELLI		14. MOTHER'S MAIDEN NAME ELAINE TERREAU	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT FATHER, SAME AS ITEM # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Memingomyelocoele DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 Apr , 19 66 , to 12 Apr , 19 66 , that (I) (we) last saw the deceased alive on 12 Apr 19 66 , and that death occurred at 5:10 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Burton A. Johnson</i> 22c. PHYSICIAN'S NAME (Type) BURTON A. JOHNSON, CAPT, MC		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12 APRIL 1966	
22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FT MEADE, MD			
23a. B. JRIAL CREMATION, (Specify) BURIAL		23b. DATE THEREOF April 19, 1966	
23c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION Cem., Lawrence, Mass..		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR APR 18 1966	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04746

CERTIFICATE OF DEATH

04746

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 44A	
3 NAME OF DECEASED (Type or print) First Middle Last Ida Bell POSTON		4. DATE OF DEATH Month Day Year April 22 19 66	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 17, 1886
9. AGE (In years lost birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min. 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William R. Thomas		14. MOTHER'S MAIDEN NAME Delia Haywood	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16 SOCIAL SECURITY NO. Betty.Tucker.Bx 44A.Davidsonville. M	
17. INFORMANT Betty.Tucker.Bx 44A.Davidsonville. M		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia (severe), Diabetes mellitus, Cerebral atrophy		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the Hospital) attended the deceased from 16 Apr 1966 to Apr. 22, 1966 that (I) (we) last saw the deceased alive on April 22, 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 9:15 AM	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS South RivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George, Md.	
24 FUNERAL DIRECTOR Lee Funeral Home		25a. BY REGISTRAR APR 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04747

04747

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u># 200 S. Hammonds Ferry Road</u>				e. STREET ADDRESS <u># 200 S. Hammonds Ferry Road</u>			
3. NAME OF DECEASED (Type or print)		First <u>I da</u> Middle <u>B.</u> Last <u>Pueschel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1878</u>		9. AGE (in years last birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine Gliewe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFIRMANT <u>Mrs. Ada Dornbush (niece)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>As Ht. fails & actual fibrill.</u> DUE TO (c) <u>Chronic dilatation of liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>4:24</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> to <u>4/24/66</u> that (I) (we) last saw the deceased alive on <u>4/24/66</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Christian S. Mass</u>		22b. DATE SIGNED <u>4/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>BALTIMORE NAT'L PIKE & ST. JOHN'S LANE</u>		22d. ADDRESS <u>ELLCOTT CITY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		24b. ADDRESS <u>Singleton Funeral Home</u>		24c. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

APR 26 1966



04748

CERTIFICATE OF DEATH

04748

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 532 Sixth St.,	
3. NAME OF DECEASED (Type or print) SARAH Sadie ELIZABETH RAWLINGS		4. DATE OF DEATH April 30 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1876
9. AGE (In years lost birthday) 89 yrs		10. IF UNDER 1 YEAR: Months 17 Days 17 Hours 17 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALONZO HUBBARD		14. MOTHER'S MAIDEN NAME ELIZABETH FREEMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT MRS Lillian Root #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Ac. myocardial infarction 4201 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 17 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus. infirmities of age		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from 4/13/66 to Apr. 30, 19 66 that (I) (we) last saw the deceased alive on Apr. 30 19 66 , and that death occurred at 10:40 AM M, from causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE SIGNED 5/2/66	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-3-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24. FUNERAL DIRECTOR John M. Lytle & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 20b Film G377 6/17/66											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04749											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Herald Harbor Rd</u>						d. STREET ADDRESS <u>Box 364 Old Herald Harbor Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Pauline</u> Last <u>Redding</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>20</u> Year <u>1966</u>								
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17, 1962</u>		9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Omaha, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael N. Redding</u>						14. MOTHER'S MAIDEN NAME <u>Mary A. Damico</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Michael N. Redding - same as #2 above</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cephalgia - Burns 3rd° blue</u> <u>9160</u> DUE TO (b) <u>Asphyx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Asphyx</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>House Fire</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>4:20</u> a.m. <u>4:20</u> p.m. <u>1966</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Anne Arundel Md.</u>			
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>4/20/66</u>											
ACTUAL SIGNATURE <u>[Signature]</u>				EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Burley E. Hopping</u>				HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR <u>APR 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06398

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Georgia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 405 Palm Drive	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle OTTO Last REED		4. DATE OF DEATH Month April Day 30 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1945
9. AGE (In years lost birthday) 21 yrs		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min 00	
11. BIRTHPLACE (State or foreign country) Monticello, Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick O. Reed Sr.		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes 65-66		16. SOCIAL SECURITY NO 259-66-7827	
17. INFORMANT U.S. ARMY records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in auto-auto collision.	
20c. TIME OF INJURY Hour 4:30 p.m. Month, Day, Year 4/30 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Annapolis A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 5/1/66	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county) Thomasville, Georgia	
23a. BURIAL, CREMATION, or other disposition BURIAL	23b. DATE THEREOF May 7, 1966	23c. NAME OF CEMETERY OR CREMATORY Laurel Cemetery	23d. LOCATION (City or town) (County) (State) Thomasville, Georgia
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REG. STRAR MAY 10 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 148
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04751														
04750														
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIEDEL ROAD</u>					d. STREET ADDRESS <u>RIEDEL ROAD</u>									
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>RIEDEL</u> Middle Last					4. DATE OF DEATH <u>4</u> Month <u>24</u> Day <u>1966</u> Year									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>THIELER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil SERVICE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <u>JOSEPH RIEDEL</u>					14. MOTHER'S MAIDEN NAME <u>THERESA STURM</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>---</u>					17. INFORMANT <u>Mrs. RAY CHAPMAN</u> Address <u>#2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>DIABETES MELLITUS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>10 YRS.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>JULY 4</u> , 19 <u>62</u> to <u>24 APR</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 APR</u> , 19 <u>66</u> , and that death occurred at <u>7P</u> M. from the causes and on the date stated above.						
22a. SIGNATURE <u>Edward S. Beck</u> M.D.					22b. DATE SIGNED <u>4-26-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>PHIL APOLIS, MD.</u>					22d. ADDRESS <u>PHIL APOLIS, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City, town or county) (State) <u>Suitland MD.</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>						
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04752

04751

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>8 FRANKLIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>HARRY G. Ruhlman</u>		4. DATE OF DEATH Year <u>1966</u> Month <u>4</u> Day <u>12</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TELLER</u>				11. BIRTHPLACE (County & State or foreign country) <u>ANNAPOLIS MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Ruhlman</u>				14. MOTHER'S MARDEN NAME <u>Matilda E. Goodwin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Christine S. Ruhlman #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>interosseleatic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>																INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>																			
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> <u>1966</u> to <u>4/13</u> <u>1966</u> that (I) last saw the deceased alive on <u>4/11</u> <u>1966</u> and that death occurred at <u>7:30</u> <u>AM</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Richard F. Hochman, M.D.</u>																			
22c. PHYSICIAN'S NAME (Type) <u>Richard F. Hochman, M.D.</u>																			
22b. DATE SIGNED <u>4/14/66</u>																			
22d. ADDRESS <u>59 Franklin St. Annapolis, Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>4-15-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>				23d. LOCATION (City, town or county) <u>ANNAPOLIS</u> (State) <u>MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis, Md.</u>																			
25a. REC'D BY REGISTRAR <u>APR 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04753

CERTIFICATE OF DEATH

04752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Millersville, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		11	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home				d. STREET ADDRESS 3019 Savoy Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Bessie Glover Ryan				4. DATE OF DEATH April 7 1966			
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1879	9 AGE (In years last birthday) yrs 86	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Glover				14. MOTHER'S MAIDEN NAME Marion Thursby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Marion Maguire-daughter same as #2 above Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH few hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 65 , to April 5 , 19 66 , that (I) (we) last saw the deceased alive on April 5 , 19 66 and that death occurred at 4:00 M, from causes on and on the date stated above.							
22a. SIGNATURE R M Smith				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH M.D.				22d. ADDRESS Severna Park Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/66		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Yonkers N.Y.	
24. FUNERAL DIRECTOR Bentley E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.				25a. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

04754

CERTIFICATE OF DEATH

04753

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB 4 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GEN HOSPITAL		d. STREET ADDRESS 225 Carroll Rd.	
3 NAME OF DECEASED (Type or print) MARIE ROSALIA SAGER		4. DATE OF DEATH Month 4 Day 8 Year 1966	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 28, 1892
9 AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 4 Days 8 IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. K. NO. OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Johnstown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Gerber		14. MOTHER'S MAIDEN NAME Kunigunda Stummer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Address John Gerber, 225 Carroll Rd., Riviera Beach			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE DUE TO (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1962 , 19, to 1966 , 19, that (I) (we) last saw the deceased alive on APRIL 8 , 19 66 , and that death occurred at 11:40 A M, from causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr MD		22b. DATE SIGNED 4-8-66	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR MD		22d. ADDRESS MOUNTAIN RD PASADENA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy., A.A.Co., Md.
24. FUNERAL DIRECTOR ADDRESS George J. Gonce - 4001 Ritchie Hgwy., Baltimore		25a. DATE APR 11 1966	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04755

04754

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY in lb. <u>North Arundel Hospital</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				d. STREET ADDRESS <u>Box 20B, Valley Road</u>			
3. NAME OF DECEASED (Type or print) <u>DOROTHY ANNA SAILORS</u>				4. DATE OF DEATH <u>April 20 19 66</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>March 10, 1919</u>				8. DATE OF BIRTH <u>March 10, 1919</u>			
9. AGE (In years last birthday) <u>47</u> yrs.				10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. Underwriter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Employers Group Assur.</u>			
11. BIRTHPLACE (State or foreign country) <u>Savannah, Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Willis Lee Scoggins</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Franklin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-18-7168</u>			
17. INFORMANT <u>Madison H. Sailors</u>				Address <u>Valley Rd., Hanover, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head.</u>							
181X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Home</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>XXXX 4/19 19 66</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>							
20f. (City or town) <u>Hanover</u> (County) <u>A.A.</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <u>Homicide</u> <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Petty</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4/21/66</u>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Apr. 23, 1966</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u> 22d. LOCATION (City, town, or country) (State) <u>Woodlawn Balto. Co. Maryland</u>							
23. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u> ADDRESS <u>1217 St. Paul Street</u> 24a. REC'D BY REGISTRAR <u>APR 25 1966</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04756

CERTIFICATE OF DEATH

04755

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Rural-Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 4, Box 115	
3. NAME OF DECEASED (Type or print) Anthony V. SAKIE		4. DATE OF DEATH Month April Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 19 Days 6 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Anthony		14. MOTHER'S MAIDEN NAME Ona	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 4538-29	
17. INFORMANT Mrs. Joseph Wiegman Mountain Rd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Repterus Atherosclerosis DUE TO (c) 2 blood loss at surgery		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 8, 1966 , to April 8, 1966 , that (I) (we) last saw the deceased alive on April 8, 1966 , and that death occurred on April 8, 1966 , from causes and on the date stated above.			
22a. SIGNATURE Stephen B. Hiltabidle		22b. DATE SIGNED APR 5 '66	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle M. D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/12/66	23c. NAME OF CEMETERY OR CREMATORY Baeso National Baeso. Md	23d. LOCATION (City or Town) (County) (State) Baeso. Md
24. FUNERAL DIRECTOR Withe H. 4101 Edmondson Ave		25a. REC'D BY REGISTRAR DATE APR 11 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>149 Greenland Beach</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 26.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>						d. STREET ADDRESS <u>149 Greenland Beach Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Clarence</u> Last <u>Sawyer</u>						4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1888</u>		9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Avon, Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>David Sawyer</u>						14. MOTHER'S MAIDEN NAME <u>Elsie Shason</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW I</u>						16. SOCIAL SECURITY NO. <u>722 149 149</u>		17. INFORMANT <u>Mrs Mary Day</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and urinary bladder</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>November 30, 1965</u> to <u>Apr. 7</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>Apr. 5</u> , 19 <u>66</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>R.M. McLaughlin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/7/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>						22d. ADDRESS <u>378 Montross Rd Pasadena Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>April 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brookdale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elyria, Ohio</u>			
24. FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hgwy., Baltimore Md.</u>						25a. REC'D BY REGISTRAR <u>APR 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

04757

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Baltimore City b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 mos. 27 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) 3-#01624 Thomas Scales		4. DATE OF DEATH Month 4 Day 11 Year 1966	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/6/1895 (approx.)
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 66 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19 66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 4/14 , 19 66 , to 4/11 , 19 66 , that (I) (we) last saw the deceased alive on 4/11 , 19 66 , and that death occurred at 8:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 4/14/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/15/66	23c. NAME OF CEMETERY OR CREMATORY Univ. of Maryland	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Wm. Reese		25a. REC'D BY REGISTRAR APR 18 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS 108 W. Wash. St. Annapolis, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

04759

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04758

1 PLACE OF DEATH a COUNTY <u>AA CO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. before admission) a STATE <u>MD</u> b COUNTY <u>AA CO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA - NORTH HAVENDEL</u>		e STREET ADDRESS <u>Sumner - N. H. Road</u>	
3 NAME OF DECEASED (Type or print) <u>Joseph W. Schwartz</u>		4 DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-10-16</u>
9 AGE (In years lost birthday) yrs <u>49</u>		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Henry Schwartz</u>		14 MOTHER'S MAIDEN NAME <u>Florence Simmons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>217-05-9082</u>	
17 INFORMANT <u>Mrs. Florence V. Schwartz</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic gangrene</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22. DATE SIGNED <u>4.24.66</u>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		DEPUTY MEDICAL EXAMINER <u>[Signature]</u> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>April 27, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d LOCATION (City or Town) (County) (State) <u>Glen Burnie, AA Co, MD</u>
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a REC'D BY REGISTRAR <u>APR 26 1966</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04750 CERTIFICATE OF DEATH 04759											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u> c. LENGTH OF STAY in 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u> d. STREET ADDRESS <u>---</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Veta</u> Middle <u>Luella</u> Last <u>Sears</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1966</u>			5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Oct. 13, 1922</u>			9. AGE (in years last birthday) <u>43</u> yrs.			10. IF UNDER 1 YEAR Months <u>02</u> Days <u>11</u> Hours <u>1</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Durango, Col.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Robert Nelson</u>					
14. MOTHER'S MAIDEN NAME <u>Ella Walker</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. <u>523-18-8246</u>						17. INFORMANT <u>Robert C. Sears</u> Address <u>same as #2 above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gen. carcinomatosis</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of breast</u> DUE TO (c) <u>---</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1946</u> , to <u>Apr. 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Apr. 11, 1966</u> , and that death occurred at <u>1 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>S. Borssuck</u> M.D.						22b. DATE SIGNED <u>4/12/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>						22d. ADDRESS <u>Amos Garrett Blvd., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Apr. 13, 1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Meth.</u>			
23d. LOCATION (City, town or county) (State) <u>Davidsonville Md.</u>				24. FUNERAL DIRECTOR <u>Barley E. Hopper</u> ADDRESS <u>HOPKING FUNERAL HOME Annapolis, Md.</u>							
25a. RECEIVED BY REGISTRAR <u>APR 14 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

04761

CERTIFICATE OF DEATH

04760

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 191 Clay St.,	
3. NAME OF DECEASED (Type or print) First Cora Middle Winfred Last STIMMS		4. DATE OF DEATH Month April Day 21 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 7, 1897
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months 0 Days 21 Hours 19 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Augustus Baden		14. MOTHER'S MAIDEN NAME Lillian Hurvill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Brenda Tenques		Address 5440 W. 11th St.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Cardiac Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis hypertensive DUE TO (c) Arterio Venous Disease		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-10-66		20f. (City or town) (County) (State) 11-20-66	
21. I certify that (I) (X) at hospital attended the deceased from 11-10-66 , 19 19 , to 11-20-66 , 19 19 , that (I) (X) saw the deceased alive on 11-10-66 , and that death occurred at 9:10 AM , from causes and on the date stated above.			
22a. SIGNATURE A. T. Allen		22b. DATE SIGNED 9:10 AM	
22c. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/66	
23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR William Reese, Jr - Annapolis, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 22 1966	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div>04762</div> <div>04761</div> </div>									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 28 W. Washington Street					d. STREET ADDRESS 28 W. Washington Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK ALEXANDER SIMPSON					4. DATE OF DEATH Month Day Year April 19 19 66				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22-1875		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef - retired		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes - S.A.W. & W.W.I			16. SOCIAL SECURITY NO. 220-09-5498		17. INFORMANT Address Annie S. Henry-28 W. Washington-Anna. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic - vascular</i> Accidental Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>6 days</i> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-7-66, 19 to 4-19-66, 19, that (I) (we) last saw the deceased alive on 4-16-66, 19, and that death occurred at 4:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>A.T. Allen</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-20-66		
22c. PHYSICIAN'S NAME (Type) A.T. Allen					22d. ADDRESS Cathedral St. Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 22-66		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill			23d. LOCATION (City, town or county) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR C.E. Hicks III Annapolis, Md.					25a. REC'D BY REGISTRAR DATE APR 25 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04763

04762

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
c. LENGTH OF STAY IN TB 18 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 600 S. Crain Highway				d. STREET ADDRESS 600 S. Crain Highway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Met A Middle DORA Last Snyder				4. DATE OF DEATH Month April Day 8 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1892	
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Clement Lehnert				14. MOTHER'S MAIDEN NAME Maria Lindeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO ----		17. INFORMANT Address Gordon Snyder, 819 Lynvue Rd., Linthicum, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 3 MIN							
42-1 DUE TO (b) Arteriosclerotic cardiovascular disease 5 yrs							
DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m p m — 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/2 19 66 , to 4/2 19 66 , that (I) (we) last saw the deceased alive on 4/2 19 66 , and that death occurred at 10 A M, from the causes and on the date stated above.							
22a. SIGNATURE R.W. Prichard M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) R.W. PRICHARD 22d. ADDRESS Glen Burnie, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce, ADDRESS 4001 Ritchie Highway Baltimore, Md. 21225							
25. REC'D BY REGISTRAR APR 11 1966 25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04761

04763

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>3 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RAY MANOR NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>2015 St. PAUL St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH ZOLLER STARR</u> First Middle Last 4. DATE OF DEATH <u>APRIL 4, 1966</u> Day Month Year		5. SEX <u>FEMALE</u> 6. CO. OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 6, 1876</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u> 12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME <u>WILLIAM H. ZOLLER</u> 14. MOTHER'S MAIDEN NAME <u>LIZZIE V. McLANE</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>MRS. JEAN S. O'DONOVAN</u> Address <u>2015 St. PAUL St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary occlusion</u> (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if EITHER, NOTIFY MEDICAL EXAMINER!) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Hour a.m. p.m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. City or town _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>May 27, 1965</u> to <u>April 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1966</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>B. M. Smith</u> 22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH M.D.</u>		22b. DATE SIGNED <u>April 4, 1966</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Severna Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>APRIL 6, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u> 23d. LOCATION (City, town or county) <u>WOODLAWN, Md.</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wick Meador</u> ADDRESS <u>805 N. Calvert St.</u> 25a. REC'D BY REGISTRAR <u>APR 6 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04765											
04764											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>112 CHARLES ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>PAUL E. STINCHCOMB</u>						4. DATE OF DEATH <u>APR. 26 1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>APR 24 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.H. Co. Gen'l.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTABLE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ANDREW J. STINCHCOMB</u>						14. MOTHER'S MAIDEN NAME <u>Mary Florence Bryn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Elnora W. Stinchcomb</u> Address <u>#2</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Arterio-sclerotic CVP</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IX hyp</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in Street</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>3-18-66</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) <u>Annandale</u> (County) <u>MD</u> (State)											
21. I certify that (I) (if hospital) attended the deceased from <u>Dec 24, 1965</u> to <u>4-26-66</u> , that (I) (we) last saw the deceased alive on <u>4-24-66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>F.M. SHIPLEY</u>						22d. ADDRESS <u>Annandale</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		23e. (State)			
<u>BURIAL</u>		<u>4-28-1966</u>		<u>ST. MARY'S CEM.</u>		<u>ANNAPOLIS MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>						25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

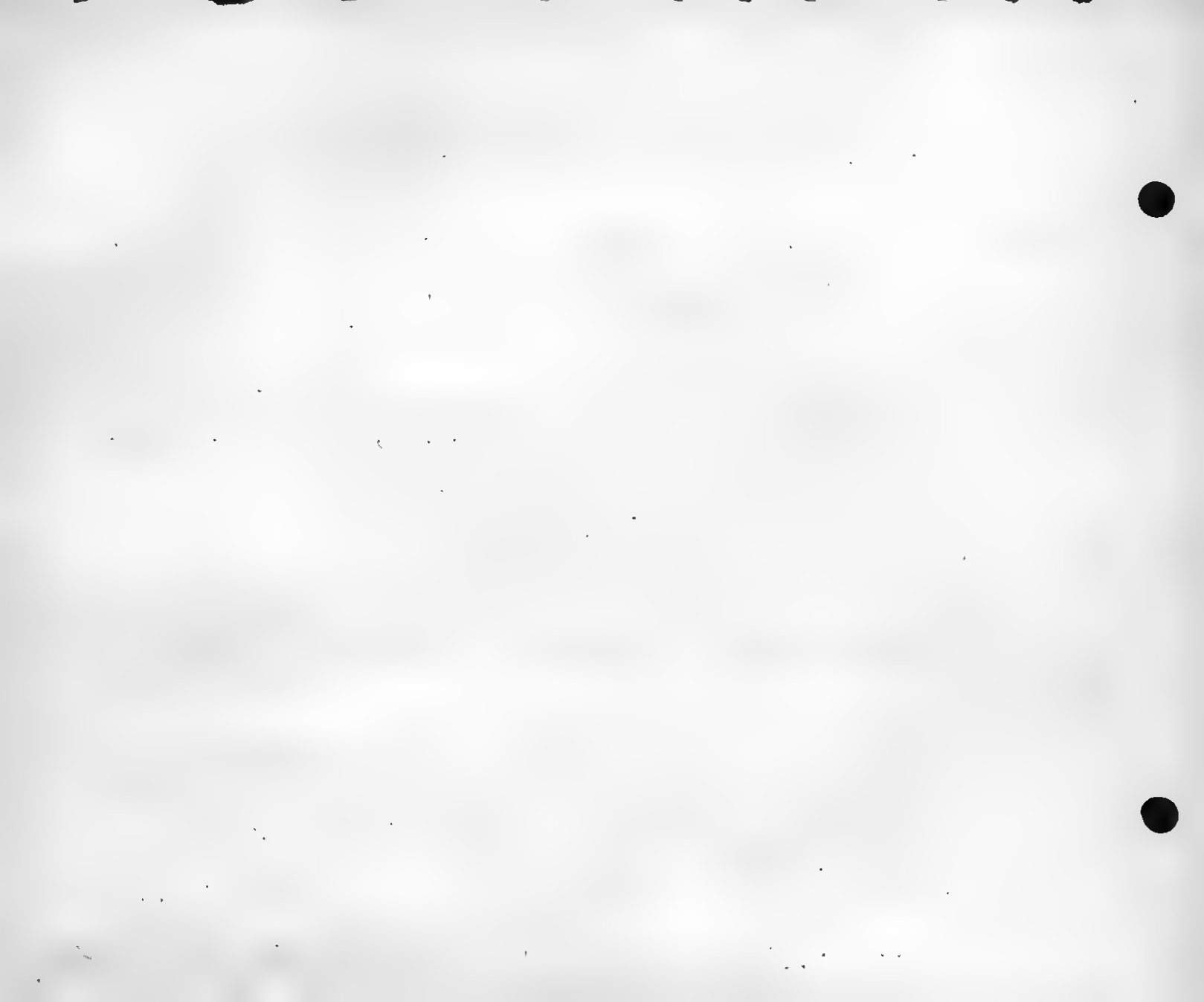
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04766
CERTIFICATE OF DEATH
04765

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Annapoles</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Maryland</i> f. COUNTY <i>Queen Anne</i> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Centreville</i> d. STREET ADDRESS		6. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anna</i> First <i>Gertrude</i> Middle <i>Taylor</i> Last		4. DATE OF DEATH <i>April</i> Month <i>17</i> Day <i>19</i> Year <i>66</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1873</i>	9. AGE (In years last birthday) <i>92</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Denton, Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Peter Foster Hignutt</i>			14. MOTHER'S MAIDEN NAME <i>Martha Jane Neal</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Anna Taylor, Centreville, Maryland</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>April 17, 1966</i> , that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>1300 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Ray M. Smith</i>		22b. DATE SIGNED <i>4-17-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>RAY M. SMITH M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>Severna Park Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 20</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield</i>	
23d. LOCATION (City, town, or county) <i>Centreville, Maryland</i>		(State)			
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>		ADDRESS <i>Church Hill, Maryland</i>		25a. REC'D BY REGISTRAR <i>APR 25 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>f Charles Judge</i>					



CERTIFICATE OF DEATH

04767

04766

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Laurel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN Tb 40 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital		d. STREET ADDRESS 1111 - 5th St., S. E.	
3. NAME OF DECEASED (Type or print) First George Middle Earl Last Taylor		4. DATE OF DEATH Month April Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-00
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert T. Taylor		14. MOTHER'S MAIDEN NAME Ellen Padgett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Children's Center Hospital, Laurel, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with metastasis 177X DUE TO Thyroid goiter Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Mental retardation (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN DEATH AND DEATH 3-23-66 to death			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February 18, 1966 to April 27, 1966 , that (I) (we) last saw the deceased alive on April 27, 1966 , and that death occurred at 1:00 p.m. from causes and on the date stated above.			
22a. SIGNATURE George T. Economos		22b. DATE SIGNED April 28, 1966	
22c. PHYSICIAN'S NAME (Type) GEORGE T. ECONOMOS, M. D.		22d. ADDRESS Children's Center, Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-2-66	23c. NAME OF CEMETERY OR CREMATORY Childrens Center	23d. LOCATION (City or Town) (County) (State) Laurel Md.
24. FUNERAL DIRECTOR DeWitt Sanadson Laurel Md		25a. REC'D BY REGISTRAR MAY 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

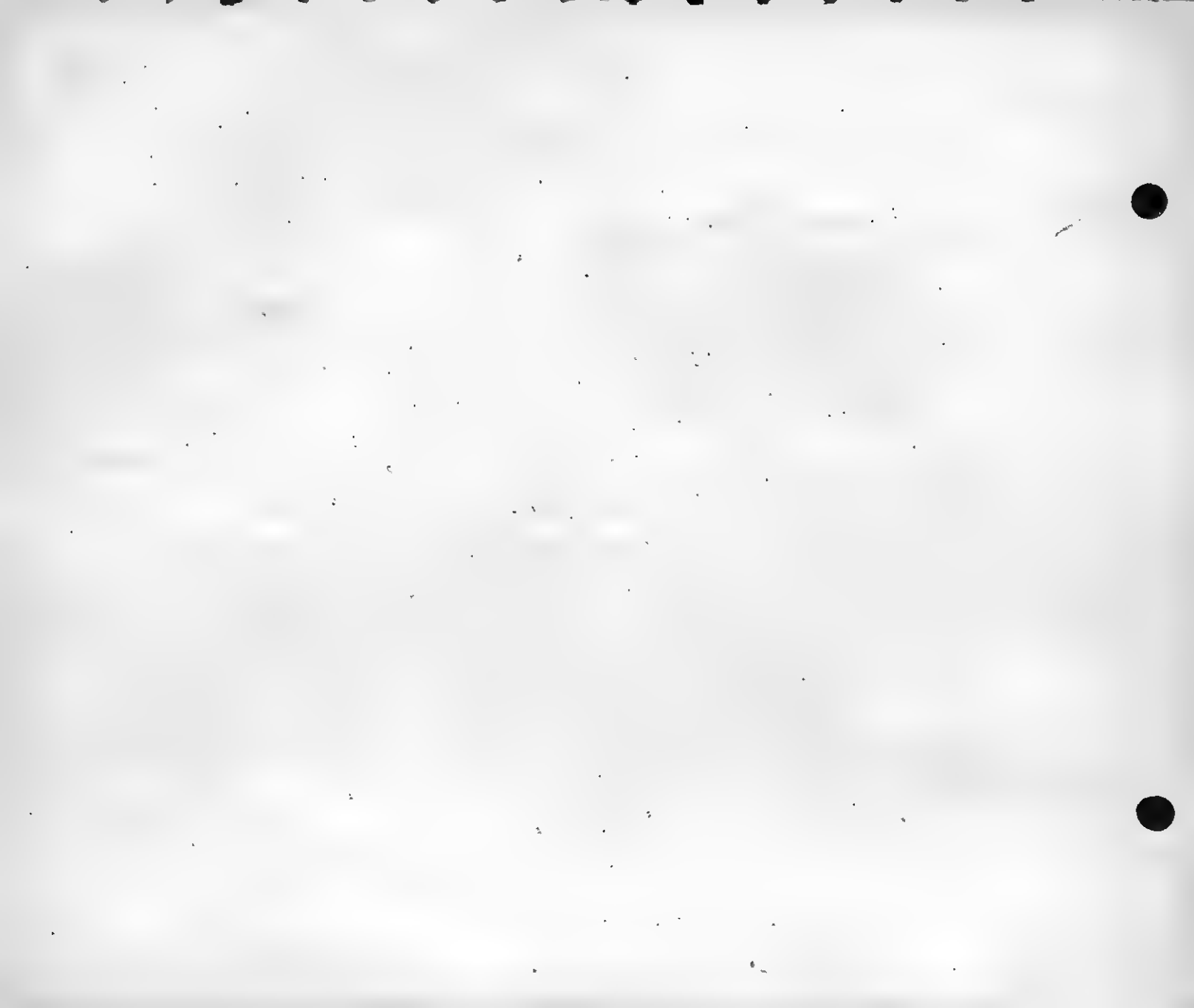
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01768
CERTIFICATE OF DEATH
01767

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>464-464</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knowlwood Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arden on the Severn - Crownsville</u> d. STREET ADDRESS <u>25 Waterview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Teufel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>
13. FATHER'S NAME <u>John Teufel</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shuey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Archie Davis</u> Address <u>33 Waterview Dr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Adeno Carcinoma of Endometrium</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 1 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>7-9, 1964</u> to <u>4-26, 1966</u> , that (I) (we) last saw the deceased alive on <u>4-14, 1966</u> , and that death occurred at <u>3:30 P.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Alexander L. Russell</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alexander L. Russell</u>		22d. ADDRESS <u>7709 Meadow Lane Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr. 29, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Fields</u>	23d. LOCATION (City, town or County) (State) <u>Millersville</u>
24. FUNERAL DIRECTOR <u>Bessie L. Hopping</u> ADDRESS <u>Hopping Funeral Home, Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04768

04768

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>98 SHIPWRIGHT ST.</u>		d. STREET ADDRESS <u>98 SHIPWRIGHT ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH MEADE THOMAS</u>		4. DATE OF DEATH Month Day Year <u>APRIL 16 1966</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1904</u>
9. AGE (in years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INDEX SUPPLIB. OF CONGRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. MEADE</u>		14. MOTHER'S MAIDEN NAME <u>EVELINA HAYES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MR. ROBERT THOMAS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. Linba</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		22. DATE SIGNED <u>APR 21 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>APR 20 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREM.</u>		23d. LOCATION (City, town or county) (State) <u>PRI. GEO. CO. MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, Soas</u>		ADDRESS <u>ANNAPOLIS</u>	
25a. REC'D BY REGISTRAR <u>APR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04770

CERTIFICATE OF DEATH

04769

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 7011A BAKER STREET	
3 NAME OF DECEASED (Type or print) First ROBERT Middle WILBURN Last TODD		4. DATE OF DEATH Month APRIL Day 22 Year 19 66	
5 SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC 6, 1930
9. AGE (In years last birthday) yrs. 35		IF UNDER 1 YEAR Months - Days - IF UNDER 24 HRS Hours - Min -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY US ARMY	11 BIRTHPLACE (County & State or foreign country) HORRY, S. CAROLINA
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BENTLEY W. TODD	
14 MOTHER'S MAIDEN NAME ALMA H. HARDEE		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES 6Sep46-22Apr66	
16 SOCIAL SECURITY NO 247-46-0663		17. INFORMANT Address OFFICIAL MILITARY RECORDS (SP NOGY)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONTACT GUNSHOT WOUND 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DESTRUCTIVE BRAIN DAMAGE (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SELF INFLICTED GUNSHOT WOUND	
20c. TIME OF INJURY Month, Day, Year Hour 2:45 p.m. APR 22 19 66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) (County) (State) FT G G MEADE, ANNE ARUNDEL MD
21. I certify that the (this hospital) attended the deceased from APRIL 22, 19 66 , to APRIL 22, 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 4:30 PM , from causes and on the date stated above			
22a. SIGNATURE <i>Fred M. Nomura</i>		22b. DATE SIGNED APRIL 22, 1966	
22c. PHYSICIAN'S NAME (Type) FRED M. NOMURA, CAPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FT MEADE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 29, 1966	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL Cem	23d. LOCATION (City or Town) (County) (State) LORIS South CAROLINA
24. FUNERAL DIRECTOR HAROLD S. WADE, 550 W 45th BLVD, LAUREL, MD		25a. REC'D BY REGISTRAR MAY 2 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04771

CERTIFICATE OF DEATH

04770

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

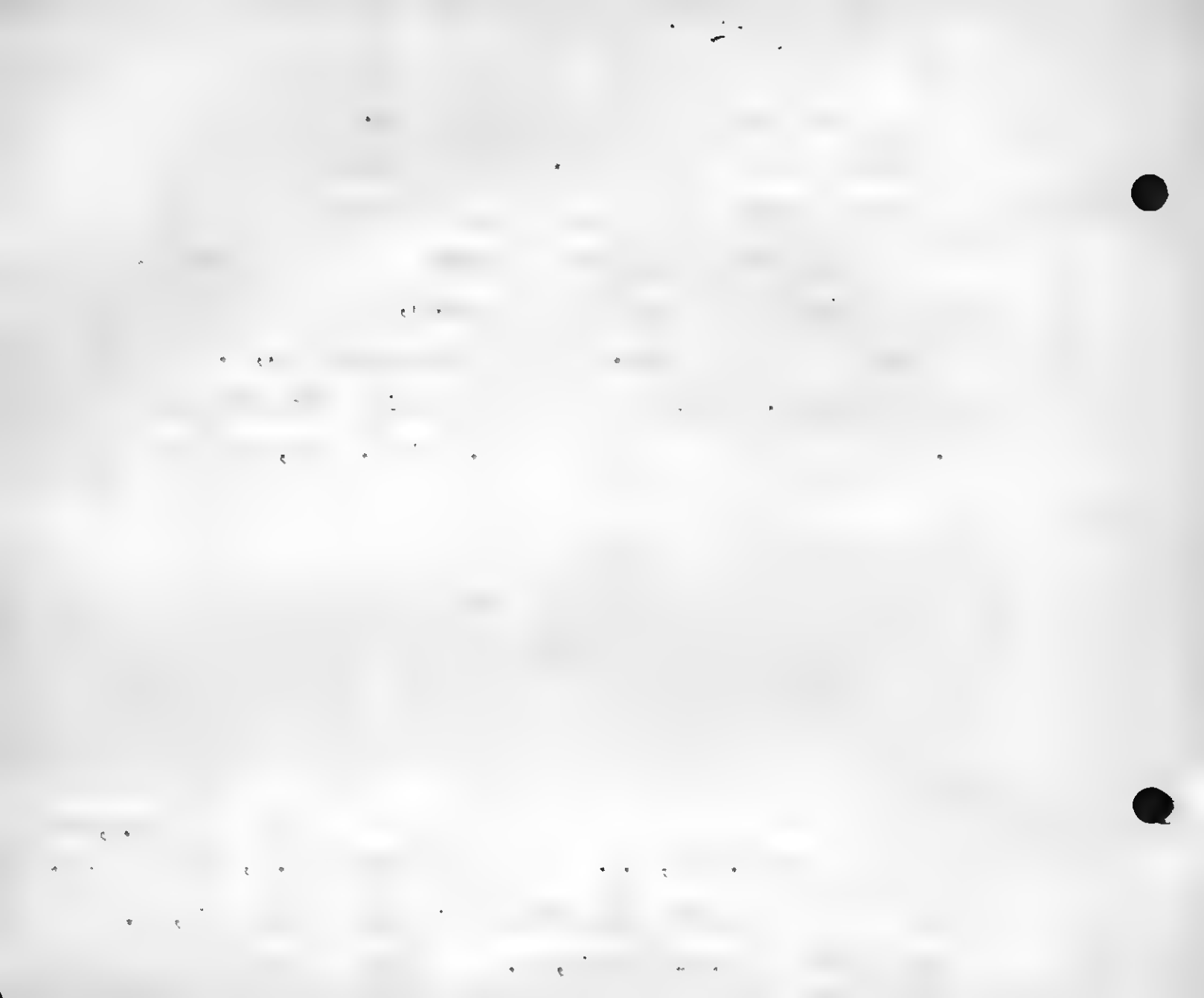
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e STREET ADDRESS 109 DUKE OF GLOUCESTER	
3 NAME OF DECEASED (Type or print) First Joseph Middle P. Last TURNER		4. DATE OF DEATH Month April Day 8 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 12 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.C. PRIEST		10b. KIND OF BUSINESS OR INDUSTRY PRIEST	11 BIRTHPLACE (County & State, or foreign country) Pennsylvania
13. FATHER'S NAME PATRICK TURNER		14. MOTHER'S MAIDEN NAME KATHERINE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT ST. MARY'S RECTORY #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 745X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia - self undetermined			INTERVAL BETWEEN ONSET AND DEATH 14 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from Feb 66 , 19 65 , to April 8 , 19 66 that (I) (we) last saw the deceased alive on April 8 , 19 66 , and that death occurred at 11:10 AM , from causes and on the date stated above.			
22a. SIGNATURE General Church		22b. DATE SIGNED 4/11/66	
22c. PHYSICIAN'S NAME (Type) GORDON E. HUNTER		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4-11-66	23c. NAME OF CEMETERY OR CREMATORY REDEMPTORIST CEM.	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A.C. MD.
24. FUNERAL DIRECTOR JOHN M. TAYLOR, 8000 ANNAPOLIS MD.		25a. REC'D BY REGISTRAR APR 13 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body at any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04773									
04772									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN 1b 70 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) New Cut Road					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY AA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS New Cut Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward		First		Middle Lee		Last Upton		4. DATE OF DEATH Month April 2, Day 19 Year 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1877		9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Upton					14. MOTHER'S MAIDEN NAME Eliza Jane Day				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.					16. SOCIAL SECURITY NO. No.		17. INFORMANT Mrs. Annie M. Upton, same as 2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Failure 6/11X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic Gastric Intestinal Infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to 4-2 , 19 66 , that (I) (we) last saw the deceased alive on April 2, 1966 , and that death occurred at 1:45 PM , from the causes and on the date stated above.									
22a. SIGNATURE Wayne B. Tate					22b. DATE SIGNED Apr. 4, 1966				
22c. PHYSICIAN'S NAME (Type) Wayne B. Tate, M.D.					22d. ADDRESS 108 Central Ave. NW, Glen Burnie, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.					25a. REC'D BY REGISTRAR APR 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

04774

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04773

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 Monticello Ave</u>		d. STREET ADDRESS <u>116 Spaw View Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Malcolm W Waring</u>		4. DATE OF DEATH Month Day Year <u>4 3 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1904</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADM. ASSISTANT</u>		9b. AGE (In years last birthday) <u>62</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>State of MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Margarets, MD.</u>	
13. FATHER'S NAME <u>J. EVERETT Waring</u>		14. MOTHER'S MAIDEN NAME <u>Masonetta Stinecomb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Augusta B. Waring #2</u>	
17. INFORMANT <u>Augusta B. Waring</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) <u>Note: I did not attend this man; death caused by Dr. Elmer Williams.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> ; that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John M. Taylor</u>		22b. DATE SIGNED <u>4/4/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-6-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>		23d. LOCATION (City, town or county) (State) <u>ARNOLD A.A. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR <u>APR 6 1966</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

[The page contains extremely faint, illegible handwritten notes.]

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04775

CERTIFICATE OF DEATH

04774

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <i>MD</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i>		c. LENGTH OF STAY IN 1b <i>Harwood</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Mary Virginia Watkins</i>		4. DATE OF DEATH Month <i>4</i> Day <i>25</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6.5.1876</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Randall</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Randall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>John H. Watkins Harwood MD</i>	
17. INFORMANT <i>John H. Watkins Harwood MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO (b) <i>hypertension Cardiovascular Disease</i> DUE TO (c) <i>ischemic</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9-5-66</i>	20f. (City or town) (County) (State) <i>Harwood A. A.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-19-66</i> to <i>4-24-66</i> , that (I) (we) last saw the deceased alive on <i>4-19-66</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>T. Allen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>T. ALLEN</i>		22d. ADDRESS <i>67 Ethelred St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 4-28-66</i>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <i>Adams</i>	23d. LOCATION (City, town or county) (State) <i>Lothian MD</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>APR 26 1966</i>	
ADDRESS <i>Annapolis</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04776

04776

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>Hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH Arundel</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
f. STREET ADDRESS <u>#1704 Tieman Drive</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>L</u> Last <u>White</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/6/10</u>	
9. AGE (in years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cowpens, S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>							
13. FATHER'S NAME <u>(Unknown) White</u>				14. MOTHER'S MAIDEN NAME <u>Sally (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>240-05-5998</u>		17. INFORMANT <u>Mrs. Carolyn L. Harbin (daughter)</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>week</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>66</u> to <u>4/28</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4/28</u> 19 <u>66</u> and that death occurred at <u>3 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Serge Vash</u>				22b. DATE SIGNED <u>4/28/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>VASH</u>				22d. ADDRESS <u>206 S. Silverside</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Brockton, MD, Maryland</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>MAY 2 1966</u>			

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

04777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04775

1 PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AMCO</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glenn Burnie</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Burnie</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00A - North - ARUNDEL -</u>				d. STREET ADDRESS <u>821 - Oak - Road.</u>			
3 NAME OF DECEASED (Type or print) <u>Rebecca C. White</u>				4 DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1966</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/24/16</u>		9 AGE (In years last birthday) yrs <u>49</u>		10 UNDER 1 YEAR Months <u>1</u> Days <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (State or foreign country) <u>Snow Camp N. Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas C. Carter</u>				14 MOTHER'S MAIDEN NAME <u>Lucy R. (unknown)</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>239-03-2696</u>		17 INFORMANT <u>Mr. Harold L. White (Husband)</u>		18 ADDRESS <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>3544</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. White</u>				22. DATE SIGNED <u>4/21/66</u>			
EXAMINER'S NAME (Type) <u>E. L. White</u>				22. DATE SIGNED <u>4/21/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Burlington, N. Carolina</u>	
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>				25a. REC'D BY REGISTRAR <u>APR 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE				c. LENGTH OF STAY IN ID 44 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE, MD.				d. STREET ADDRESS 1 DAVID LEE RD	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LUCINDA			First Middle Last WHITT			4. DATE OF DEATH Month Day Year APRIL 2 1966					
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Sept 1889		9. AGE (In years last birthday) 76 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) HOCKING OHIO		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE WASHINGTON HUTCHINSON						14. MOTHER'S MAIDEN NAME ANGELINE TATEMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK				16. SOCIAL SECURITY NO. UNK		17. INFORMANT MARY E. CHAMP (DAU)		Address CATONSVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIFFUSE CARCINOMATOSIS (c) CARCINOMA OF BREAST						INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 18 FEB 1966 to 2 APR 1966, that (I) (we) last saw the deceased alive on 12 FEB 1966, and that death occurred at 920PM, from the causes and on the date stated above.											
22a. SIGNATURE Jeffress Boozer						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2 APR 66			
22c. PHYSICIAN'S NAME (Type) JEFFRESS BOOZER/CAPT/MC						22d. ADDRESS KIMBROUGH ARMY HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral				23b. DATE THEREOF 4/4/66		23c. NAME OF CEMETERY OR CREMATORY St. Michaels		23d. LOCATION (City, town or county) (State) Catonsville, MD			
24. FUNERAL DIRECTOR W. Sickman						ADDRESS 1111 N. Gate Rd		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE APR 4 66 Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04779											
04778											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY AA MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Md. b. COUNTY AA						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BrooklynPk						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ordinance Rd.					d. STREET ADDRESS Ordinance Rd.						
3. NAME OF DECEASED (Type or print) First Albert Middle Henry Last Wiedenhoef					4. DATE OF DEATH Month 4 Day 6 Year 1966						
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 28, 1902		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Block Layer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Leland Wiedenhoef					14. MOTHER'S MAIDEN NAME Anna						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Stoll Address Ordinance Rd. # 26						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency - Hypertension DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1966 to April 6, 1966 , that (I) (we) last saw the deceased alive on April 6, 1966 , and that death occurred at 9A M, from the causes and on the date stated above.											
22a. SIGNATURE Loung Glass					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4/6/66			
22c. PHYSICIAN'S NAME (Type) LC					22d. ADDRESS 320 PATAPSCO AVE						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-8-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town or county) (State) Beth 25 Md.				
24. FUNERAL DIRECTOR McCully Funeral Home					ADDRESS 237 Patapsco Ave. 25		25a. REC'D BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

04780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04779

1. PLACE OF DEATH a COUNTY <u>A.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, f institution: Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>A.A.C.O.</u>	
b CITY OR TOWN (f outside corporate limits write RURAL and give nearest town) <u>Frederick New Burnie</u>		c LENGTH OF STAY IN lb <u>Passover</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DOD - NORTH AVENUE - Hospital</u>		e STREET ADDRESS <u>129-Boaz 202. -</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie E.</u> Middle <u>WILKES</u> Last <u>WILKES</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1893</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>217-22-6240</u>	
17. INFORMANT <u>John Wilkes</u>		Address <u>1029 W. Lexington St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis Generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>4-8-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>4/14/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem Ph</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S ADDRESS <u>Ashtington S. Phillips 1727 N. Monaca St</u>		25a. REC'D BY REGISTRAR DATE <u>APR 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CROWNSVILLE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNE R ARUNDEL c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIOLET Middle WILKINSON Last 4. DATE OF DEATH Month APRIL Day 29 Year 1966		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8-22-1897 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 6 Days 7 IF UNDER 24 HRS: Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) MARYLAND, USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILIP TIPPETT		14. MOTHER'S MAIDEN NAME HANNAH NORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 577-12-2456 B	
17. INFORMANT WILMER E. WILKINSON		Address HOLLYWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DEPRESSIVE REACTION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/14/66 to 4/29/66 ; that (I) (we) last saw the deceased live on 4/29/66 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Donald McHenry Mapp		22b. DATE SIGNED 4/29/66	
22c. PHYSICIAN'S NAME (Type) Donald McHenry Mapp		M.D. ADDRESS Crownsville State Hospital, Crownsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-3-66	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph		23d. LOCATION (City or Town) (County) (State) Hollywood, Md.	
24. FUNERAL DIRECTOR W. CLARK MATTINGLEY		25a. REC'D BY REGISTRAR MAY 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G5.6 7/2/66 mh

04782

CERTIFICATE OF DEATH

04781

1. PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>✓</u>					
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Crownsville</u>		c LENGTH OF STAY IN 1b <u>1 mo. 18 Das</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d STREET ADDRESS <u>1018 Stodard Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>#31467</u> <u>Cora</u> <u>Williams</u> First Middle Last				4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>19 66</u>					
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-5-76</u>	9 AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Foster</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>ND</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Decubitus Ulcers & Gangrene of Lower Left (b) <u> </u> DUE TO Extremity & Senility (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH			
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> <u> </u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Crownsville, Maryland</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/7/</u> , 19 <u>66</u> to <u>4/25/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/25/</u> , 19 <u>66</u> , and that death occurred on <u>11:15</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Lionel Henry Mapp</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4/25/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lionel Henry Mapp, M.D.</u>				22d. ADDRESS <u>Crownsville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>4/29/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>			
24. FUNERAL DIRECTOR <u>Margaret Hayes</u> ADDRESS <u>638 N. Gilmor St</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04783

CERTIFICATE OF DEATH

04782

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN b. <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL Hosp't</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAY RIDGE</u>	
3. NAME OF DECEASED (Type or print) <u>CORNELIA</u>		f. STREET ADDRESS <u>224 W. LAKE DR.</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-1876</u>	
9. AGE (In years last birthday) <u>89</u>		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DARIUS WATERHOUSE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>H.V. WITHERSPOON #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>0045</u> DUE TO <u>Acute leukemia, acute type not known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1965</u> to <u>April 1966</u> , that (I) (we) last saw the deceased alive on <u>April 14 1966</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/15/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>FOREST DR. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>4-15-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>APR 18 1966</u>	
ADDRESS <u>ANNAPOLIS, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04784											
04783											
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS 1709 N. Calvert Street						
3. NAME OF DECEASED (Type or print) First Middle Last #30111 Anna T. Wright					4. DATE OF DEATH Month Day Year 4 4 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/21/80		9. AGE (In years last birthday) 85 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME UNKNOWN Nicholas Tegges					14. MOTHER'S MAIDEN NAME UNKNOWN Margaret Miller						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-0070		17. INFORMANT Miss Lula M. Masch (Hospital Records) 3808 Fleetwood							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus Ulcers (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arteriosclerotic Cardia Vascular Disease Mellitus										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Crownsville, Maryland											
21. I certify that (I) (this hospital) attended the deceased from 8/9/1965 to 4/4/1966, that (I) (we) last saw the deceased alive on 4/4/1966, and that death occurred at 9:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Lionel McHenry Mapp, M.D.					22b. DATE SIGNED 4/4/66						
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.					22d. ADDRESS Crownsville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/66		23c. NAME OF CEMETERY OR CREMATORY St Matthews			23d. LOCATION (City, town or county) (State) Baltimore Maryland				
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTO. MD.					25a. REC'D BY REGISTRAR APR 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

31
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

31
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04785
04784
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #34 COLONIAL DRIVE				d. STREET ADDRESS #34 COLONIAL DRIVE			
3. NAME OF DECEASED (Type or print) First IOA Middle YEAGER Last				4. DATE OF DEATH Month APRIL Day 11, Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 15, 1887	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK (ret.)				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME SAMUEL FINK			
14. MOTHER'S MAIDEN NAME AGNES (unknown)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. 194 10 0921				17. INFORMANT MRS. DOROTHY WILKIE (daughter) SAME AS #			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X CORONARY THROMBOSIS DUE TO (b) ATHERO-sclerosis, Hypertension DUE TO (c) diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH Two days 5 years 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gout, gall stone, bleeding diverticulitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Jan, 1960, to 4.10.1966, that (I) (we) last saw the deceased alive on 4.10.1966 and that death occurred at 3 AM, from the causes and on the date stated above.				22a. SIGNATURE Bahram Sina M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED APRIL 11, 1966			
22c. PHYSICIAN'S NAME (Type) BAHRAM SINA				22d. ADDRESS #11 E. CHASE ST., BALTIMORE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF APRIL 14, 1966			
23c. NAME OF CEMETERY OR CREMATORY FREEMSBURG CEMETERY				23d. LOCATION (City, town or county) (State) BETHLEHEM, PENNSYLVANIA			
24. FUNERAL DIRECTOR R.V. SINGLETON ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge			
25c. DATE APR 13 1966							

18520

7

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04786 CERTIFICATE OF DEATH 04785

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt 2 Box 73</u>		d. STREET ADDRESS <u>Rt 2 Box 73</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Rudolph Young</u>		4. DATE OF DEATH Month Day Year <u>4-11-66</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7 1908</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eng</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Young</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215094288</u>	
17. INFORMANT <u>Chester Young</u>		Address <u>Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>C.C.V.D.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-5-66</u> 19 <u>66</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Halber</u> M.D.		22b. DATE SIGNED <u>4-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Halber</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>4-14-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>Severna Park Fun. Home, Severna Park, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

